Third Edition

COUNSELING THEORY AND PRACTICE

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Counseling Theory and Practice

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Preface

Welcome to the third edition of *Counseling Theory and Practice*. Developed for helping professionals, *Counseling Theory and Practice* explores what it means to be an effective helper, provides an overview of foundational theories of counseling and psychotherapy, and gives students and others the opportunity to explore their views of human nature, so they can effectively adopt a theory of their own.

New to This Edition

- Expanded information on social, cultural, and spiritual issues for each of the theoretical approaches
- Updated scholarship on each counseling theory's efficacy and effectiveness
- Use of inclusive pronouns (e.g., they, them, and their)
- Updated citations, referencing, and information about theories
- Removal of chapters on behavior therapy and on adaptations, spinoffs, and new directions (Note: These chapters can still be accessed, upon request, from Cognella Academic Publishing.)
- Addition of a new section on emerging and contemporary theories

Layout of the Book

Chapter 1, which focuses on professional, ethical, multicultural, and social justice issues, begins by providing a discussion regarding the differences between counseling and psychotherapy. It then examines evidenced-based practice (EBP), which speaks to the importance of research supported treatments and clinical expertise in positive client outcomes. This is followed by a review of several common factors to all counseling theory approaches that have been shown to be important in positive client outcomes (e.g., a strong therapeutic alliance and being able to effectively deliver one's theoretical approach). The chapter moves on to defining "theory" and explains why having a theory, based on one's view of human nature, is critical if one is to be a competent counselor. This is followed by an examination of how counselors often integrate different theories into their own, unique, approach as they gain increased expertise. The chapter then reviews many ethical issues related to practicing counseling and offers an overview of prominent models of ethical decision-making. In addition, we highlight best practices to ensure the counselor is performing at optimal levels and to reduce the probability of malpractice lawsuits. The chapter then highlights the importance of decolonizing counseling theory—that is, understanding those aspects of theory that have historically been destructive to marginalized clients. This is followed by an overview of the multicultural and social justice counseling competencies, which offer a model for the effective counseling of diverse clients. The chapter concludes by introducing the Miller family, and we note that at the conclusion of each theory chapter, one member of the Miller family undergoes the type of counseling that was reviewed in the chapter. This is followed by a series of 10–13 questions, related to the vignette just read, which asks the reader to critically reflect on how the theory was

applied to the individual just discussed. We think you'll find this an interesting and fun way to understand the theory.

Following Chapter 1, you will find five sections, primarily organized into schools of thought. Section 1 explores psychodynamic approaches to counseling and psychotherapy, including psychoanalysis (Freudian therapy), analytical therapy (Jungian therapy), and individual psychology (Adlerian therapy). Section 2 is devoted to existential–humanistic approaches, such as existential therapy, Gestalt therapy, and person-centered counseling, while Section 3 discusses cognitive–behavioral approaches, including rational emotive behavior therapy (REBT), cognitive-behavioral therapy (CBT), and reality therapy. Section 4 describes postmodern therapies and examines narrative therapy, solution-focused brief therapy (SFBT), and relational–cultural therapy (RCT), which is a form of feminist and cross-cultural therapy. Finally, Section 5 examines three emerging and contemporary theories: dialectical behavior therapy (DBT), acceptance and commitment therapy (ACT), and neurocounseling (See Table 0.1).

TABLE 0.1. An Overview of the Text

Introduction Foundations of Counseling Theory and Practice	Chapter 1 Professional, Ethical, Multicultural, and Social Justice Considerations (and Introducing the Miller Family)		
Section I Psychodynamic Theories	Chapter 2 Psychoanalysis (Freudian Therapy)	Chapter 3 Analytical Psychology (Jungian Therapy)	Chapter 4 Individual Psychology (Adlerian Therapy)
Section II Existential–Humanistic Theories	Chapter 5 Existential Therapy (Frankl and Others)	Chapter 6 Gestalt Therapy (Perls)	Chapter 7 Person-Centered Counseling (Rogers)
Section III Cognitive and Behavioral Theories	Chapter 8 Rational Emotive Behavior Therapy (Ellis)	Chapter 9 Cognitive-Behavioral Therapy (Beck)	Chapter 10 Reality Therapy (Glasser)
Section IV Postmodern Approaches	Chapter 11 Narrative Therapy (White)	Chapter 12 Solution-Focused Therapy (Berg and de Shazer)	Chapter 13 Relational Cultural Therapy (Miller)
Section V Contemporary and Emerging Theories	Chapter 14 Dialectical Behavior Therapy (Linehan)	Chapter 15 Acceptance and Commitment Therapy (Hayes)	Chapter 16 Neurocounseling

Each theory chapter (Chapters 2 through 16) provides a history of the prominent theorist who developed the theory; the theory's view of human nature; key concepts; important techniques; the therapeutic process; social, cultural, and spiritual issues; efficacy of the theory; and a summary. And as just noted, at the conclusion of each chapter is a vignette that examines one member of the Miller family going through the type of counseling you just read about followed by 12 questions to help you critically reflect upon the theory.

In addition to foundational information, *Counseling Theory and Practice* features fact sheets, illustrative vignettes, experiential exercises, an electronic survey that helps students examine their

view of human nature, and a complementary website that introduces readers to great therapists of the 20th century. Additionally, video files are provided to demonstrate most of the theories of the book and help students see how the approaches are enacted. We believe we have made the book interesting, readable, comprehensive, and down to earth and hope you will find this new edition of *Counseling Theory and Practice* an important addition to you helping professions' library.

Acknowledgments

A lot of people assisted in the development of a book, and we would like to acknowledge some of them. First, Kassie Graves, Senior Vice President, Editorial, and Amy Smith, Senior Project Editor.

We would like to again acknowledge several people who originally helped review and, in some cases, write parts of the various theories in the book. They include Ted Remley (ethics and integrative counseling); Allen Bishop (psychoanalysis); Thomas Eisner (analytical therapy); Richard Watts (Adlerian therapy); Cheree Hammond (existential therapy); Paula Justice (Gestalt therapy); Howard Kirschenbaum (person-centered counseling); Korrie Allen (rational emotive behavior therapy); Garrett McAuliffe (cognitive therapy); Rosanne Nunnery (dialectical behavior therapy); Bob Wubbolding (reality therapy); Tracie Richards, John C. Wren, Robert R. Armbruster, and Abie Tremblay (acceptance and commitment therapy); Francisca Rivas, Ne'Shaun Borden, Johana Rocha, and Kyulee Park (dialectical behavior therapy); John Winslade (narrative therapy); Richard Watts (solution-focused brief therapy); and Carlos Zalaquett and Lauren Parker (neurocounseling). A special thanks to Cheree Hammond, who wrote a large number the Miller family members' journey through counseling. Also, thanks to Kittrell Brielle's updates of the references and Angela Johnson's review of the efficacy research for the chapters. Finally, I'd like to thank Kevin Hernandez, Alexandra Johnston, and Matthew Wade for their assistance on the ancillaries and other general help with the book.

INTRODUCTION

FOUNDATIONS OF COUNSELING THEORY AND PRACTICE

1 Professional, Ethical, Multicultural, and Social Justice Considerations (and Introducing the Miller Family)

Learning Goals

At the conclusion of this chapter, readers will:

- have knowledge about the characteristics and efficacy of counseling and psychotherapy
- be able to provide a rationale for using theory when practicing counseling and psychotherapy
- define one's view of human nature and worldview
- understand the relationship between theory and the development of an integrative approach to counseling and psychotherapy
- identify typical stages for developing an integrative approach to counseling and psychotherapy
- have knowledge of the historical background and purpose of ethical codes
- identify major ethical topics found in most ethical codes that are relevant to the counseling and psychotherapy relationship
- understand models of ethical decision-making, including problem-solving models, moral models, developmental models, and the social constructionist perspective
- identify best practices that can assist in practicing counseling ethically and responsibly
- be cognizant of the importance of culturally responsive helping when practicing counseling and psychotherapy
- have knowledge of the multicultural and social justice counseling competencies
- be familiar with the case of the Millers, who will be discussed throughout the text

This chapter serves as a foundation to the role of theory when practicing counseling and psychotherapy. First, we describe counseling and psychotherapy and articulate its effectiveness for improving client mental health and wellness. Then, we define theory and the five historical forces within counseling and psychotherapy that shape it. Next, we discuss two aspects of developing one's theoretical orientation: understanding one's view of human nature as well as the stages of integrative counseling and psychotherapy. Ethical codes and considerations within counseling theory and practice are then presented, followed by a rationale for culturally responsive practice by applying the multicultural and social justice counseling competencies (Ratts et al., 2015). The chapter concludes with a case description of the Millers.

Counseling and Psychotherapy

In the training of helpers today, *counseling* and *psychotherapy* are generally used interchangeably. Despite their common usage, most people acknowledge differences in the practice of counseling and psychotherapy, as seen in Figure 1.1.

Counseling		Psychotherapy
short-term	>>>>>>>>>>>>>>>>>>>>	long-term
surface issues	>>>>>>>>>>>>>>>>>>>>	deep-seated issues
"massaging" personality	>>>>>>>>>>>>>>>>>>>>	personality reconstruction
here and now	>>>>>>>>>>>>>>>>>>>>	there and then
conscious	>>>>>>>>>>>>>>>>>>>>	unconscious
moderate client revelations	>>>>>>>>>>>>>>>>>>>>	deep client revelations
uncomfortable	>>>>>>>>>>>>>>>>>>>>	painful
focused issues	>>>>>>>>>>>>>>>>>>>>	life stories

FIGURE 1.1 The Differences Between Counseling and Psychotherapy

Whether one ends up practicing counseling or psychotherapy, as just defined, is probably dependent on several factors, including:

- whether the expectation of the client is to have an experience of counseling or of psychotherapy,
- the comfort level of the helper with the practice of counseling vs. psychotherapy,
- the degree of support within a practice setting for practicing counseling versus psychotherapy,
- the number of sessions available for clients, with counseling generally lasting fewer sessions than psychotherapy,
- whether the client's and helper's focus are in sync for the practice of counseling or psychotherapy,
- whether the helper has worked through their issues that will allow the in-depth work that is necessary in psychotherapy, and
- the belief of the helper in the efficacy of practicing counseling or practicing psychotherapy (i.e., the belief that one approach might work better than another).

Based on the distinction made in Figure 1.1, some of the theories discussed in this book clearly lean more toward counseling, while others toward psychotherapy. For instance, solution-focused brief therapy (SFBT; Chapter 12) tends to lean toward the practice of counseling. In contrast, psychoanalysis (Chapter 2) is heavily oriented toward the psychotherapy end of the continuum. Many of the theories discussed in this text, however, could easily fit on either end of the spectrum. So as you read the text, consider the following:

1. How comfortable are you with doing counseling or psychotherapy?
2. What would you *prefer* to do: counseling or psychotherapy?
3. Have you worked through your own issues to ensure they do not interfere with your ability to practice counseling or psychotherapy?
4. Which theories lend themselves more toward counseling versus psychotherapy?
5. Which theories would you include in the way you do counseling or psychotherapy?

Our approach in this text will be to use the words "counseling" and "psychotherapy" interchangeably. This does not necessarily endorse the notion that they are the same but provides the reader and opportunity to discern for themself whether an approach is "counseling" or "psychotherapy."

Effectiveness of Counseling and Psychotherapy

Are counseling and psychotherapy effective? In 1952, *Hans Eysenck* examined 24 uncontrolled studies that looked at the effectiveness of psychotherapy on treatment outcomes and found that "roughly two-thirds of a group of neurotic patients will recover or improve to a marked extent within about two years of the onset of their illness, *whether they are treated by means of psychotherapy or not* [emphasis added]" (p. 322). Although Eysenck's research was found to have serious methodological flaws, it did lead to debate concerning the effectiveness of counseling and resulted in hundreds of studies that examined its usefulness. Years later, analyses of many studies revealed something very different than what Eysenck had found. For example, in 1995 Seligman noted that clients in long-term treatment fared better than those in short-term treatment, treatment effectiveness did not significantly differ based on treatment approach or therapist type, and psychotherapy alone did not differ in effectiveness from medication plus psychotherapy. More recently, based on extensive research, Wampold (2019) found:

> In clinical trials, psychotherapy results in benefits that far exceed the benefits of those who do not get psychotherapy. Indeed, psychotherapy is more effective than many commonly used evidence-based medical practices, some of which have onerous side effects and are quite expensive (Wampold, 2007; Wampold & Imel, 2015). In addition, psychotherapy is as effective as medications for prevalent mental disorders, is longer lasting, and is less resistant to additional courses. (p. 72)

But what is it that makes counseling effective? First and foremost, *client factors*, such as readiness for change, psychological resources, and social supports, may affect how well a client does in counseling (Norcross & Wampold, 2019). In addition, in recent years, it has become evident that counseling and psychotherapy work best when the counselor or therapist (a) knows the best available research-supported treatments; (b) uses their clinical expertise to understand the client's situation and chooses the most effective treatments for it; and (c) when the client's personal preferences, values, and cultural background for such treatment are considered. Called *evidence-based practice* (EBP; American Psychological Association [APA], 2021), this approach to working with clients has become an important focus in training programs and in work settings.

In addition to EBP, *common factors* that underly all therapeutic approaches have been shown to be related to positive client outcomes (Cuijpers et al., 2019). For instance, the ability to show empathy, the capacity to build a therapeutic alliance, knowing your approach well enough to build client expectations that it will work for the client's presenting problem (regardless of the approach), and being facile at implementing specific techniques of your approach to facilitate client change are all critical factors to positive client outcomes (Hilsenroth, 2014; Wampold, 2015, 2019; Wampold & Imel, 2015).

You will notice remarkable differences among the theories within this text. Based on EBP, some do work better than other approaches for specific problems and disorders. However, because any of the theories can embrace the common factors, to some degree all can be successful with most clients.

Theory

Do you remember learning about the atom and how it is composed of a nucleus with electrons floating around it like a solar system? And we were told, all matter is made up of these atoms.

What if this is not the case? What if this *theory*—which seems to fit our way of understanding the world—is incorrect? Well, some physicists today say the atom is actually a series of string-like entities, which vibrate and make up an astronomical number of parallel universes (Mann, 2019). They call this *string theory*.

Whether string theory will be "proven" to define the intricacies of the universe (and other universes!) is a mystery we will have to live with for a while. However, the idea that theories evolve as our understanding of the world evolves is a known fact. The development of new knowledge periodically leads to paradigm shifts, wherein a marked change in the perception of our world takes place. So it was with the discovery that the earth was round and with Einstein's theory of relativity, and so it will be when a cure for cancer is found or a new counseling theory is developed. New knowledge is based on sound scientific hunches, connected to all of what has come before, and only later corroborated by scientific evidence.

Theory helps to conceptualize client concerns, determine what techniques to apply, and predict client change (Barth et al., 2019; Neukrug, 2015). A *reductionist* approach, theory helps us analyze and describe phenomenon (e.g., a person's mental health experience), so the counselor can provide a consistent and generalizable response to the person's situation (Hackney & Cormier, 2016; Kress et al., 2021). In addition, theories are *heuristic*; that is, they are researchable and testable and allow us to discard those aspects shown to be ineffective and build on those aspects that seem to work best. As new knowledge in the helping professions is created, counselors and psychotherapists will have at their disposal innovative and more effective ways of engaging in the helping relationship. One thing is guaranteed: As you embrace new knowledge and new theories and engage in dynamic counseling relationships, whatever theory you start out practicing will look different than the theory you employ when you retire.

In the late 1800s, *Sigmund Freud* put forth the first comprehensive theory of psychotherapy (i.e., psychoanalysis) and created a shift in thinking in the Western world. His ideas about the unconscious, intrapsychic forces, and sexuality changed the way the Western world perceived human nature—and still does to this day. However, his theory was not developed in a vacuum; it evolved because others before him had pondered similar questions. Over the years, we have learned that we can discard some of Freud's theory, accept other aspects, and continue to examine the rest.

Today, major counseling theories are typically characterized by *forces*, which are paradigms or shared understandings of thought and practice that guide counseling theory and practice (Gladding, 2017; Hackney & Cormier, 2016; Ratts & Pedersen, 2014; Sue et al., 2019), There are five major forces of counseling and psychotherapy, with later forces providing a greater understanding of human nature and human development based on current knowledge. Consequently, new and adapted theories were introduced into counseling and psychotherapy. The forces are as follows:

- **psychodynamic:** The psychodynamic force originated from the work of Freud, who eschewed the existing medical approaches in the treatment of certain diseases (e.g., hysteria) and, instead, thought they were of a psychological nature. Freud posited that human behavior was shaped by biological drives, psychosexual development, and memories repressed within the unconscious mind. Psychoanalysis or "talk therapy" allowed individuals, through techniques such as free association and dream analysis, to gain insight and bring unconscious thoughts to the conscious mind for healing. As discussed in Chapters 2–4, various theories associated with this paradigm focus on constructs, such as instinctual drives (i.e., id), differentiation of self, transference, defense mechanisms, ego, and superego.
- **existential–humanistic:** The existential–humanistic force grew from critiques of the psychodynamic and cognitive-behavioral approaches to counseling and had a major focus of

cultivating personal meaning. This paradigm emphasizes that mental health is achieved through seeking personal responsibility and insight, identifying human potential and purpose, and possessing an innate view of human nature as good. Through modeling empathy and genuineness, this approach assumes that counselors and psychotherapists can understand the subjective world of the client and assist them to lead more fulfilling lives. In Chapters 5–7, constructs such as existential anxiety, will to meaning, figure/ground, unfinished business, empathy, congruence, and unconditional positive regard are discussed.

- **cognitive-behaviorism:** Shaped by behaviorism and cognitive schools of thought and in reaction to psychoanalysis, the cognitive-behavioral force focused on addressing cognitive processes (e.g., learning, memory, and self-talk) to enact cognitive or behavioral change. The systematic study of observable behavior or reported cognitions provides insight to change thoughts and behaviors, which leads to mental well-being. The cognitive-behavioral paradigm is characterized by concepts such as behavior modification, disputing irrational beliefs, understanding automatic thoughts and core beliefs, desensitization, education, and cognitive disputations (see Chapters 8–11).
- **multiculturalism–postmodernism:** The multiculturalism–postmodernism force was born from emerging thought about contextual and cultural influences on mental well-being and the imperative for culturally responsive practice. The client was viewed as a cultural being whose identity is developed from contexts in which they live. For this paradigm, counselors and psychotherapists focus on developing multicultural counseling competency to build their awareness, knowledge, skills, and actions to serve a culturally diverse clientele. Concepts such as identity development, narratives and counternarratives, social constructionism, solution-oriented questions, feminism, and postmodernism are explored further in Chapters 12–14.
- **social advocacy:** The newest force, social advocacy, emphasizes how the clients' presenting issues are largely in response to oppression and systemic barriers they experience within larger sociopolitical contexts. Individual and collective trauma are viewed as antecedents to mental illness, and counselors and psychotherapists guide clients and communities (and themselves) through raising critical consciousness, community building, fostering resilience, and engaging in social action. Opportunities to apply this paradigm are especially possible among multicultural and postmodern theories presented in Chapters 12–14.

Developing Your Theoretical Orientation

One's *theoretical orientation* is generally an outgrowth of one's *worldview* or *view of human nature*, which include a large array of attributes that individuals may embrace in their understanding of personality development. Some of these include the impact of biology, including genetics; the impact of the environment; early childrearing patterns; placement in the family; the belief regarding whether people are born a blank slate, good, bad, or somewhere in between; the belief that unconscious factors impact development; a focus on hierarchical versus collectivistic decision-making; one's orientation toward nature and time; whether one is a doer or a be-er (e.g., reflective thinker); language used in society; laws developed by society; how one's religion might impact development; and much more (Kluckhohn & Strodtbeck, 1961; Sue, 1978; White, 2011).

In addition, Sue (1978) identified two intersecting dimensions that may impact one's world view worldview and view of human nature, *locus of responsibility* and *locus of control*, both of which can have an internal or external focus. An *internal locus of responsibility* suggests that issues are a result of one's own doing, while an *external locus of responsibility* proposes that the environment is responsible for issues. An *internal locus of control* suggests that the individual has greater personal control over their environment, while an *external locus of control* refers

to consequences that are outside of one's control. The silhouettes in Figure 1.2 show a few of the infinite number of ways a person can view locus of control and responsibility. Where do you think you fall on this graphic? After you consider where you are, complete Reflective Exercise 1.1, and begin to form your view of human nature and gain a better understanding of your worldview. After you have completed Reflection Exercise 1.1, complete Experiential Exercise 1.1 and examine with which theories and schools you are most affiliated.

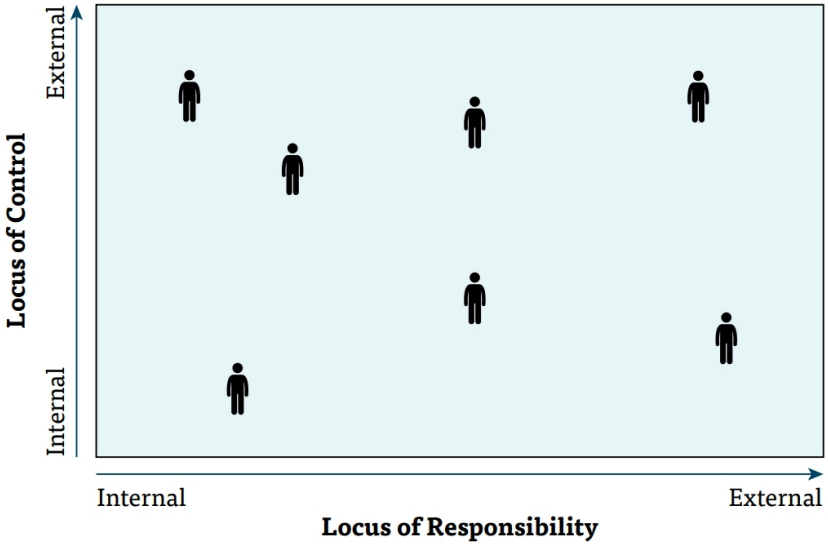

FIGURE 1.2 Interaction of One's Locus of Control and Locus of Responsibility

REFLECTION EXERCISE 1.1 Understanding Your View of Human Nature

For each of the following five statements, circle all items that best describe your beliefs. Then, using your responses as a guide, develop a paragraph or two that describes your view of human nature and worldview. Feel free to add other items.

1. At birth, I believe people are born:
   a. good
   b. bad
   c. neutral
   d. with original sin
   e. restricted by their genetics
   f. with a growth force that allows them to change throughout life
   g. capable of being anything they want to be
   h. with sexual drives that consciously and unconsciously affect their lives
   i. with aggressive drives that consciously and unconsciously affect their lives
   j. with social drives that consciously and unconsciously affect their lives
   k. with other attributes: _____

2. Personality development is most influenced by:
   a. genetics
   b. learning
   c. early child-rearing patterns
   d. drives
   e. values we are taught
   f. environment
   g. relationships with others
   h. biology
   i. instincts
   j. modeling the behavior of others
   k. developmental issues (e.g., puberty)
   l. conscious decisions
   m. the unconscious
   n. language
   o. feelings of inferiority
   p. primordial images
   q. other: _____

3. As people grow older, I believe they are:
   a. capable of major changes in their personalities
   b. capable of moderate changes in their personalities
   c. capable of minor changes in their personalities
   d. incapable of change in their personalities
   e. determined by their early childhood experiences
   f. determined by their genetics
   g. determined by how they were conditioned and reinforced
   h. determined by unconscious motivations
   i. able to transcend or go beyond early childhood experiences

4. Change is likely to be most facilitated by a focus on:
   a. the conscious mind
   b. the unconscious mind
   c. thoughts
   d. behaviors
   e. feelings
   f. early experiences
   g. the past
   h. the present
   i. the future
   j. the use of medications
   k. unfinished business
   l. repressed memories
   m. biology
   n. language
   o. memories
   p. one's "real" self
   q. other: _____

5. The ability to change can be greatly impact by the following external factors:
   a. a person's cultural background
   b. one's extended family
   c. oppressive forces in society
   d. discrimination and racism
   e. laws developed by society
   f. the kinds of language used in society
   g. values we grow up with
   h. religious beliefs one has

EXPERIENTIAL EXERCISE 1.1 View of Human Nature Survey

This text highlights several popular and long-standing individual approaches to therapy, each of which is based on a unique view of human nature. A website Neukrug developed contains an instrument you can use to examine which of many of the theories found in this text are most

affiliated with your view of human nature. You will also be able to discover with which therapeutic school you are most aligned (i.e., psychodynamic, existential–humanistic, cognitive-behavioral, or postmodern). Take the following survey to see the theories and schools with which you are most affiliated:

- *Survey to Assess Your View of Human Nature*: www.odu.edu/~eneukrug/therapists/survey.html

Integrative Counseling and Psychotherapy

As you can see from the last section, counselors and psychotherapists' understanding of what causes a client's presenting problem, and the capacity to change one's problems, is instrumental to developing their theoretical orientation. For example, theories linked with certain forces (e.g., psychodynamic, existentialism–humanism, and cognitive-behaviorism) would typically view individuals as responsible for their symptomology and in control of their outcomes. Other forces (e.g., multiculturalism–postmodernism and social advocacy) might consider the environment primarily responsible for client's presenting concerns, and thus, outcomes are increasingly found outside of the client's control. Of course, most theories fall somewhere along the middle of the continuum for these two dimensions.

Typically, a helper's theoretical orientation changes over time, and most counselors and psychotherapists combine varying theoretical approaches into their own way of working with clients as their career develops (Corey, 2018). In fact, in recent years, about one-fourth of mental health professionals have identified themselves as using a purely integrative approach (Norcross et al., 2016). In many ways, as most of us mature as professionals, we take on a more integrative approach as our adherence to one theoretical orientation becomes less rigid and we incorporate other ideas into our way of doing counseling and psychotherapy.

Formerly called *eclecticism*, an *integrative approach* to counseling and psychotherapy is when the helper develops a core theory by integrating elements from different theories into their practice. Unfortunately, some counselors or psychotherapists who say they are using an integrative approach are actually practicing a mishmash of techniques that have little or no underlying theoretical basis. This type of *atheoretical eclecticism* is counterintuitive and considered by many to be "shooting-from-the-hip" therapy. Integration of this kind is *not* based on systematic research and is detrimental to the goals of our profession and, more importantly, to the successful treatment of clients. Effective helpers, on the other hand, know that an integrative approach involves a deliberate effort at integrating techniques into the helper's repertoire.

Developing an integrative approach in counseling and psychotherapy has been described using various models (see Corey, 2018; Cutts, 2011; Norcross et al., 2016); however, most of these models possess some common elements or stages to arrive at a metatheory.

- **stage 1—chaos:** This initial stage, aptly called the *chaos stage*, finds the counselor or psychotherapist having limited knowledge of theory and involves moment-to-moment, subjective judgments. Often practiced while students are still in training programs, we see in this stage helpers' first attempt to use the various skills they have learned, such as when they do role-plays or work with volunteer clients. This kind of approach has limited success with clients, as there is haphazardness and a lack of focus with the helper's use of skills.
- **stage 2—coalescence:** As theory is learned, most helpers drift toward adherence to one approach. Although they mostly ascribe to one theory, in the *coalescence stage*, they are beginning to use some techniques from other approaches when they believe it would be helpful to clients.

- **stage 3—multiplicity:** During the *multiplicity stage*, helpers have increasingly learned one theory and are beginning to gain a solid knowledge of one or more other theories. They are also now beginning to realize that multiple theories may be equally effective for many clients. This knowledge presents a dilemma for the counselor: "What theoretical perspective should I adhere to, and how might I combine, or use at various times, two or more theoretical perspectives, so I can offer the most effective treatment?" Ultimately, helpers can feel comfortable with different approaches and, thus, sometimes integrate other approaches into their main approach.
- **stage 4—metatheory:** When helpers reach the *metatheory stage*, they have become an expert counselor or psychotherapist and have settled into a theoretical orientation based on their work with clients and the gathering of knowledge about theories over the years. The metatheory is a thought-through approach that defines their work and usually incorporates several different elements from many theories into their way of doing counseling and psychotherapy. This incorporation yields a unique style of helping. For instance, the humanist will use behavioral techniques but from the framework of the humanistic perspective. The ability to assimilate techniques from varying theoretical perspectives into one well-thought-out approach takes knowledge, time, and finesse.

If you are just beginning your journey as a counselor or therapist, as your career evolves you will likely pass through these four stages as you begin to sort through the various theoretical approaches and develop your own unique style of counseling (see Figure 1.3).

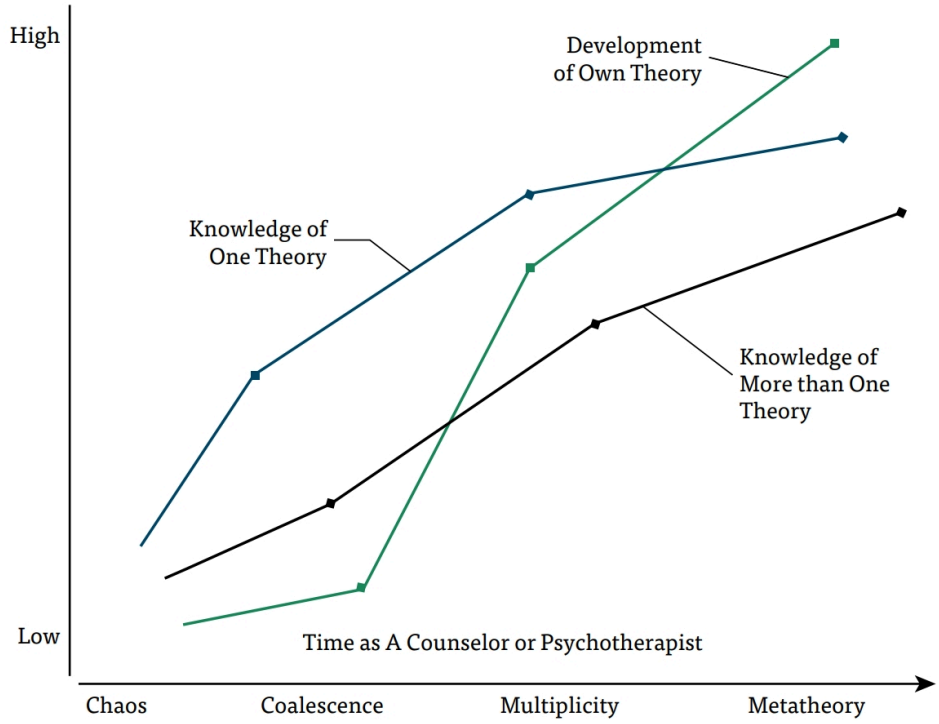

FIGURE 1.3 The Development, Over Time, of an Integrative Approach

Ethics

Regardless of the theoretical approach you will take in your journey as a counselor or psychotherapist, you will face some thorny ethical issues. Therefore, having a strong background in ethics and ethical decision-making and being facile with your ethical code is a critical quality all clinicians must have. Professional *ethics* is a set of guidelines established within a professional discipline to guide thinking and behavior. This section of the chapter highlights the background and purpose of ethical codes, spotlights ethical issues related to the counseling relationship, provides ethical decision-making models that can be applied when faced with ethical dilemmas, and offers some pointers for providing best practices so that you are less likely to provide unethical services or be sued.

Ethical Codes

The helping professions saw the establishment of *ethical codes* during the midpoint of the twentieth century, when, in 1953, the American Psychological Association (APA) published its first code of ethics. Not long after, in 1960, the National Association of Social Workers (NASW) adopted its code, and in 1961, the American Counseling Association (ACA) developed its ethical code. More recently, the National Organization of Human Services (NOHS) developed its ethical code (NOHS, 1996). The associations' guidelines have undergone several major revisions over the years to reflect society's ever-changing values as well as the changing values of the associations (see ACA, 2014; APA, 2017; NASW, 2021; NOHS, 2015). Today, ethical codes of professional associations are remarkably similar and serve the same general purposes (Corey et al., 2019; Dolgoff et al., 2012; Remley & Herlihy, 2019):

- They protect consumers and further the professional standing of the organization.
- They are a statement about the maturity and professional identity of a profession.
- They guide professionals toward certain types of behaviors that reflect the underlying values considered to be desirable in the profession.
- They offer a framework in the sometimes-difficult ethical decision-making process.
- They can be offered as one measure of defense if the professional is sued for malpractice.

Although ethical guidelines can be of considerable assistance in a professional's ethical decision-making process, there are limitations to the use of such a code:

- Codes do not address some issues and offer no clear way of responding to other issues.
- There are sometimes conflicts within the same code, between related codes, between the code and the law, and between the code and a helper's value system.
- It is sometimes difficult to enforce ethical violations in the codes.
- The public is often not involved in the code construction process, and the public interests are not always considered.
- Codes do not always address "cutting edge" issues.

Although ethical codes cover a wide variety of possible counseling and consulting relationships, certain ethical hot spots are repeatedly addressed in research, discussed in classes, and found to be concerns by practitioners (Carlisle et al., in press; Çerkez et al., 2018; Wilkinson et al., 2019). Box 1.1 highlights some of these concerns, differentiated by categories in which they logically fit. After you review these hot spots, complete Experiential Exercise 1.2.

BOX 1.1 Counseling "Hot Spots" Aggregated by Logical Categories

Counseling Relationship/Boundaries

- bartering for counseling services
- encouraging clients to text a counselor
- expressing strong feelings toward a client
- giving clients one's personal phone number
- pressuring a client to receive needed services
- becoming sexually involved with a former client
- hugging a client (e.g., to say hello, goodbye, or to console a client)
- attending a client's wedding, graduation, or other formal ceremony
- conducting counseling while walking through a park or other informal way
- selling a product to your client related to the counseling relationship (e.g., a book)

Values and Culture

- publicly advocating for a cause
- referring a client due to cultural differences
- referring a prospective client due to religious differences
- encouraging all client's autonomy and self-determination
- choosing not to counsel an LGBTQ+ person due to values differences
- referring a client before the first session due to values differences
- accepting clients only from specific cultural, ethnic, or gender groups

Confidentiality and Legal Issues

- seeing a minor without parental consent
- not reporting when you suspect spousal abuse
- guaranteeing confidentiality for group members
- guaranteeing confidentiality for couples and families
- withholding information about a minor despite a parent's request
- sharing confidential information with an administrator or a colleague who is not your supervisor
- warning a third party (e.g., spouse, significant other, or sexual partner) of exposure to a communicable and life-threatening disease

Legal and Professional Issues

- misrepresentation of credentials to the public
- breaking the law to protect your client's rights
- allowing a mandated client to refuse counseling services
- not allowing clients to view process notes about them (notes to jog one's memory)
- refraining from making a diagnosis to protect a client from a third party (e.g., an employer)

Professional Responsibility

- taking on medication compliance monitoring
- not being a member of a professional association in counseling

- failure to obtain necessary continuing education credits for credential
- reporting a colleague's unethical conduct without first consulting the colleague
- using techniques that are not theory or research based
- not providing "pro bono" services to clients who cannot afford services
- not contacting another mental health professional with whom your client is actively working

Technology

- Allowing client access to a counselor's personal social media (e.g., Facebook)
- Having a professional website that is not accessible for people with hearing and visual impairments
- Not creating a specific informed consent document focused on distance counseling
- Viewing a client's personal information online without informing your client (e.g., Twitter, Facebook, their blog, or Google)

Models of Ethical Decision-Making

Although ethical codes provide guidelines regarding how to make decisions, ultimately, it is the helper who is the decision-maker. Making thorny ethical decisions can be difficult, and decision-making models have been developed to help us in this process. Four such models include problem-solving models, moral models, social constructionist models, and developmental models.

Problem-solving models provide counselors and psychotherapists with pragmatic, step-by-step approaches to making ethical decisions. One such practical model is an eight-step approach: (a) identifying the problem or dilemma, (b) identifying the potential issues involved, (c) reviewing the relevant ethical guidelines, (d) knowing the applicable laws and regulations, (e) obtaining consultation, (f) considering possible and probable courses of action, (g) enumerating the consequences of various decisions, and (h) deciding on the best course of action (Corey et al., 2019). This and other similar models can be great aids to the clinician in the sometimes-difficult ethical decision-making process.

While Corey's model emphasizes pragmatism, *moral models* that stress inherent principles or virtues to which the counselor should subscribe when making ethical decisions are also popular (Hill, 2004). *Karen Kitchener's* (1984, 1986; Urofsky, et al., 2008) principle ethics model is often described as the foundation or core of ethical codes. Her model describes the role of five moral principles that individuals should consider in the process of ethical decision making: (a) *autonomy* has to do with protecting the independence, self-determination, and freedom of choice of clients; (b) *nonmaleficence* is the concept of "do no harm" when working with clients; (c) *beneficence* is related to promoting the good of society, which can be at least partially accomplished by promoting the client's well-being; (d) *justice* refers to providing equal and fair treatment to all clients; and (e) *fidelity* is related to maintaining trust in the counseling relationship (e.g., keeping conversations confidential) and being committed to the client within that relationship. A sixth moral principle, called *veracity*, is often added to the above five principles. Attributed to Meara et al. (1996), *veracity* has to do with being truthful and genuine with the client within the context of the counseling

EXPERIENTIAL EXERCISE 1.2
What Is Ethical?

Have your instructor distribute the various situations listed in Box 1.1 to students in the class. Then, using your ethical code, see if you can find if and how they are addressed in your ethics code. When you have finished, students can share their findings with the class.

relationship. The clinician who employs this moral model will use all of these principles to guide their decision-making process.

One particularly recent addition to ethical decision making, the *social constructionist perspective,* sees knowledge (e.g., information in codes about how to make wise ethical decisions) as intersubjective, changeable, and open to interpretation (Cottone, 2001; Guterman & Rudes, 2008; Raskin & Debany, 2017). This perspective suggests that realities are socially constructed, constituted through language, organized and maintained through narrative (stories), and there are no essential truths (Freedman & Combs, 1996). Taking a *postmodern* perspective, they believe that traditional ways of viewing ethical dilemmas could, at times, be problematic and are often the result of the language used and embedded in one's culture and in society. Such language, they suggest, is sometimes oppressive of others, particularly those from nondominant groups. They question what we often take for granted when making ethical decisions, such as having a client diagnosis drive the decision-making process or having one's theoretical perspective push a counselor toward certain ways of acting. Instead, the social constructionist looks to have a dialogue with others to develop new ways of understanding situations. These others may include the client, others intimately involved with the client, and the counselor's supervisor. And sometimes, they suggest all should sit and talk together about the solution. The social constructionist approaches clients with humility, as equals, with wonder, and as collaborators with whom solutions to ethical problems can be jointly worked out with them and with others.

Developmental models, influenced by individuals like Lawrence Kohlberg (1984), William Perry (1970), and Robert Kegan (1982, 1994), suggest that individuals at "lower" levels of development have less of some qualities that are considered positive for counselors than those who are at "higher" levels (Lloyd-Hazlett & Foster, 2017; Wagner & Hill, 2015). These models assert that counselors at lower levels of development would want "the answer" to complex ethical dilemmas, adhere to a rigid view of the truth, and expect (or, at the very least, hope) that such formal documents as ethical codes hold the answer to complex ethical dilemmas. They are also likely to look at those in positions of authority and power (e.g., supervisors) as being able to quickly tell them the correct answer when faced with thorny ethical dilemmas. These counselors can be said to be making meaning from what Perry calls a *dualistic perspective*, in that they view the world in terms of black and white thinking, concreteness, rigidity, oversimplification, stereotyping, self-protectiveness, and authoritarianism. In contrast, higher-level counselors, sometimes called individuals *committed in relativism*, would be more complex thinkers, open to differing opinions, flexible, empathic, sensitive to the context of the ethical dilemma, and nondogmatic (Lambie et al., 2009; Lambie et al., 2010; Lloyd-Hazlett & Foster, 2017; McAuliffe & Eriksen, 2010). Although few adults (or counselors) reach the highest levels of this development, these models suggest that, if afforded the right opportunities, most can. Training programs often offer opportunities to support and challenge students to move toward these higher levels of development (Landon & Schultz, 2017; Letourneau, 2016; Purgason et al., 2016).

In sum, counselors and psychotherapists are effective, ethical helpers when they are familiar with their ethical codes; understand and reflect on the moral questions involved; intentionally examine problem-solving models, such as those suggested by Corey et al. (2019); are reflective, thoughtful, and complex decision-makers; and are willing to honestly discuss ethical concerns with their clients and with others. It is essential that counselors and psychotherapists are equipped with the clinical knowledge and tools necessary to make the best decisions when working with clients.

Avoiding Ethical Violations Through the Use of Best Practices

In addition to using the ethical decision-making models just identified, Corey and his colleagues (2019) offer a number of *best practices*, which identify ways in which a clinician can ensure that he or she has been following best practices (see Box 1.2).

BOX 1.2 Avoiding Ethical Violations and Malpractice Suits

1. Know relevant laws.
2. Maintain good records.
3. Keep your appointments.
4. Ensure security of records.
5. Stay professional with clients.
6. Document treatment progress.
7. Have a sound theoretical approach.
8. Preserve appropriate confidentiality.
9. Obtain informed consent from clients.
10. Maintain the confidentiality of records.
11. Report cases of abuse as required by law.
12. Treat only within your area of competence.
13. Avoid imposing your values or influence on clients.
14. Obtain written permission when working with minors.
15. Refer when it is in the best interest of your client to do so.
16. Be attentive to your clients' needs, and treat them with respect.
17. Avoid engaging in sexual relationships with current or former clients.
18. Make sure that clients understand information that you present to them.
19. Obtain permission from a client to consult with others, whenever possible.
20. Ensure that clients understand that they can terminate counseling at any point.
21. Know cultural and clinical issues related to bartering and accepting or giving gifts.
22. Monitor your reactions to clients, especially when countertransference is involved.
23. Assess clients, and explain diagnoses and treatment plans and their risks and benefits.
24. Provide a professional disclosure statement, and obtain informed consent regarding course of treatment.
25. Keep appropriate boundaries, and know limitations of multiple relationships (e.g., counseling a person who is a neighbor).
26. Know how to appropriately assess for clients who may pose a danger of harming self or others, and know what to do if you think a client poses a threat.

Culturally Competent Counseling and Psychotherapy

As we conclude this chapter, the topic of engaging in *culturally responsive counseling and psychotherapy* is critical for developing and applying counseling theory into practice. As noted earlier in the chapter, multiculturalism–postmodernism and social advocacy have been described as the

fourth and fifth forces of counseling, respectively (Ratts et al., 2015; Wampold, 2015). These two forces are intended to expand and critically examine psychological theory of the previous forces in counseling (i.e., psychoanalysis, existential–humanism, and cognitive-behaviorism), while offering an opportunity to deconstruct and reconstruct counseling theory to be culturally responsive to clients (LaGuardia, 2023; Pedersen et al., 2008). As you read the various theories in this text, you will find that many of the theorists were culturally encapsulated, or reliant on their own cultural groups as a reference and standard for normality. Invariably, this resulted in their theories being best suited for the populations with which they were developed—usually White men, and to a lesser degree, White women.

Counseling is attending more to the complexities of both counselors and clients in their cultural makeup, the systems by which they are surrounded, and the impact these two components have on mental health. In addition, counselors are challenged to address personal biases and assumptions that prevent the formation of an affirming, therapeutic alliance with clients. *Multicultural counseling* is counseling that actively considers the influence of the counselor and client's cultural identities on the counseling relationship, process, and outcome. *Culture* refers to the shared values, practices, social norms, and worldviews associated with a particular cultural group (e.g., race, ethnicity, gender, sexual orientation, and spirituality; Hays & Gay, 2023). The degree to which individuals identify themselves as belonging to subgroups of various cultural groups or categories (i.e., cultural identity) is influenced by their historical and contemporary experiences with others within and outside of a particular cultural category (Hays & Gay, 2023). *Social advocacy* is grounded in community-level change and calls attention to inequities across societal institutions, such as educational, legal, and healthcare. Through social advocacy, counselors recognize the impact of privilege, oppression, and discrimination on the social, educational, mental health, and other outcomes of individuals and communities (Gnilka et al., 2023; Toporek & Daniels, 2018).

During the past several decades, there has been significant attention to the role of culture in mental health expression and treatment factors. As the U.S. population diversifies, counselors are increasingly aware of the role that culturally based contextual factors play in the counseling process. These factors include inaccessibility of services, stigma and mistrust, prejudice and discrimination, immigration, acculturation, resilience, and individual and collective trauma (Hays & Gay, 2023). Thus, counselors have an ethical and professional imperative to understand client contexts and worldviews and incorporate them into their theoretical frameworks ACA, 2014; Council for Counseling and Related Education Programs [CACREP], 2016; Ratts et al., 2015).

Furthermore, cultural factors play a role in whether individuals—particularly, historically underrepresented racial and ethnic groups, those of lower socioeconomic status, and nonnative English speakers—seek and remain in mental health treatment (Cadaret & Speight, 2018; Cheng et al., 2018; Weissman et al., 2015). In addition, individuals with lower levels of acculturation may perceive or experience more barriers to seeking help and may report stigma or mistrust of the counseling profession (Pham et al., 2017; Sun et al., 2016). In fact, a perceived or actual lack of access to mental health services has been linked to poorer clinical outcomes, such as suicide, hospitalization, and maladaptive social and occupational functioning (Lee et al., 2014), and the failure to provide culturally- and social justice–oriented care as part of any services delivered can be detrimental to clients from oppressed statuses and lead to premature termination of mental health services (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Thus, culturally responsive practice is an ethical imperative. Consider the questions posed in Reflective Exercise 1.2 regarding ethical concerns and multicultural counseling.

REFLECTION EXERCISE 1.2 Ethical Concerns Related to Multicultural Counseling

The following ethical and professional issues will allow you to use your ethical code and decision-making models while you focus on cross-cultural concerns. Your instructor can either have you examine them on your own or in small groups in class.

1. Because of cross-cultural differences, you believe that your work with an Asian client has not been successful. Rather than referring the client to another counselor, you decide to read more about your client's culture to gain a better understanding of him. Is this ethical? Is this professional?
2. A colleague of yours consistently makes misogynistic (dislike of women) statements when referring to clients. What should you do?
3. A colleague of yours identifies herself as a feminist counselor. You know that when she works with some women, she actively encourages them to leave their husbands when she discovers the husband is verbally or physically abusive. Is she acting ethically? Should you do anything?
4. You discover that a colleague of yours is telling a gay client that he is acting immorally. Is this ethical, professional, and legal? What should you do?
5. A friend of yours advertises that she is a Christian counselor. You discover that when clients come to see her, she encourages reading parts of the Bible during sessions and tells clients they need to ask repentance for their sins. Is this ethical? Is this professional?
6. A Black counselor in private practice has expertise in working with a specific mental health problem that is often exhibited by Black males. A White client, who has the same problem, has heard that this counselor is quite effective and calls him for an appointment. The counselor refers him to someone else and tells the client he works only with Black people. Does the Black counselor have a responsibility to see this client? Is he acting ethically, professionally, and legally?
7. When working with an Asian client who is not expressive of her feelings, a counselor you know pressures the client to express feelings. The counselor tells the client, "You can only get better if you express yourself." Is this counselor acting ethically and professionally? Do you have any responsibility in this case?
8. When offering a parenting workshop, you are challenged when you tell them that "hitting a child is never okay." They tell you that you are crazy and that sometimes a good spanking is the only thing that will get the child's attention. Do they have a point? What should you do?
9. A counselor who is seeing a client who is HIV positive discovers that his client is having sex with others without revealing his HIV status. The counselor tells the client that he has a responsibility to report the client to the police. Would this be ethical, professional, and legal?
10. A colleague of yours is working with a Latina client who states there is little hope for happiness in her marriage. The client states that her husband's attitude toward her is constantly demeaning, but there is little she can do. After all, she tells you, it is "out of her control" and "in God's hands." Your colleague tells you she is helping the client gain autonomy and to give up the notion of *fatilismo*—that fate controls one's life—a common value held by many Hispanics. Is your colleague acting appropriately? Is there a better way for the colleague to respond?
11. A clinician you work with is using a theory that clearly has biases when working with women and some minority clients. This clinician does little to adapt the theory to suit women and minorities. What should you do?

Decolonizing Counseling Theory and Practice

Traditional counseling theories are often critiqued for centering on the individual to enact change, without adequate attention to culture and related contextual factors. Furthermore, they often fail to consider intersectional cultural identities and resultant multiple, intersectional systems of cultural privilege and oppression. Jordan (2017) refers to this value of hyperindividuality as the *decontextualized self*, which primarily serves the interests of dominant groups in U.S. society: Individual growth and success is prioritized, and psychological growth is limited as social and cultural inequities are perpetuated. Jordan goes on to note that independence is a myth that cannot be fully achieved and is based on masculine psychological development in which autonomy and individuation are signals of psychological strength with an undergirded assumption that clients hold power within their own lives.

A focus on hyperindividuality and independence can perpetuate a cycle of marginalization by negating the impact of systemic oppression and marginalization for culturally diverse clients. Furthermore, by failing to intentionally integrate the value of interdependency and relationships within client mental health and wellness, counseling service delivery is inadequate and harmful. Without sufficient attention to culture, privilege, and oppression, counselors will create therapeutic environments that disadvantage clients and develop interventions and practices that are ineffective. Jordan (2017) echoes this sentiment:

> If we keep examining and altering the intrapsychic or small circle factors and do not intervene to shift the underlying dynamics that create problems in the larger circles (e.g., individualistic worldview, poverty, abuse, mythic equality of opportunity), we fail not just our clients but also our society and ultimately our planet. To place culture alongside connection at the center of theory is to break a critical silence. (p. 230)

Thus, counselors and psychotherapists applying traditional theories should focus on clients' culture and marginalization experiences when conceptualizing mental health and counseling practice (Singh et al., 2020). Infusing culture and social advocacy within theory can provide more culturally responsive and decolonized counseling practices. As you review theories presented in this text, consider how cultural and social justice issues intersect with theoretical assumptions, practices, and potential outcomes. Box 1.3 provides some general recommendations for *decolonizing counseling theory and practice*.

BOX 1.3 Decolonizing Traditional Counseling Theory and Practice

- Study the history of how traditional counseling theories are situated and developed over time. Who developed these theories? What values and beliefs does each theory reflect? How does each theory define the "presenting problem," and what does it propose as solutions? What does each theory assume leads to psychological growth?
- When using traditional counseling theories, consider the impact of larger societal forces on the client, and do not assume that problems are inherently within the person.
- Consider how culture is socially constructed and stratified as well as how culture shapes norms and values and for whose benefit.
- Explore how external barriers encountered by clients are prohibiting mental health and wellness.
- Brainstorm structural changes that are needed to reduce harm related to oppression.

Note. Adapted from Singh et al., 2020.

Multicultural and Social Justice Counseling Competencies

Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2015) provides counselors a framework for adapting, deconstructing, and reconstructing traditional counseling theories or implementing culturally responsive and decolonized counseling practices. Specifically, the MSJCC call for counselors to "develop knowledge of theories that explain how their privileged and marginalized status influences their experiences and worldview" (p. 5). They comprise a set of guidelines that calls attention to the awareness, knowledge, skills, and counseling and advocacy interventions required to counsel in a multiculturally competent manner.

As depicted by the MSJCC, a critical analysis of power of which counselors and clients holds, particularly as it relates to cultural privilege and oppression, is necessary to decolonize counseling practice. The MSJCC conceptual framework provides quadrants that illustrate the different combinations of privilege and oppression that may occur between counselors and clients. These quadrants are as follows: Quadrant I: privileged counselor–marginalized client; Quadrant II: privileged counselor–privileged client; Quadrant III: marginalized counselor–privileged client; and Quadrant IV: marginalized counselor–marginalized client (see Figure 1.4).

The MSJCC also includes four developmental domains of which counselors should attend: counselor self-awareness, the counseling relationship, the client's worldview, and counseling and

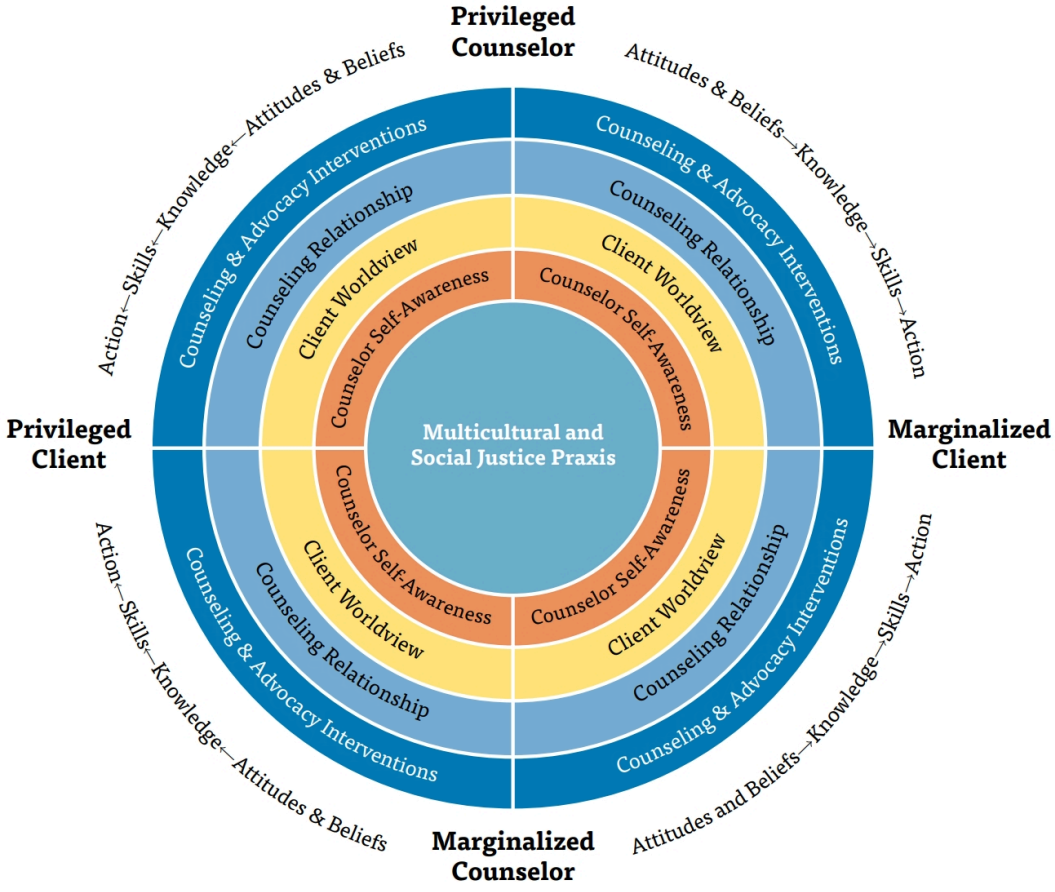

FIGURE 1.4 Multicultural and Social Justice Counseling Competencies

advocacy interventions. Throughout each of these development domains, there are aspirational competencies designated across attitudes and beliefs, knowledge, skills, and action. For example, for the counselor self-awareness domain, counselors are to be cognizant of their own worldview and combination of privileged and oppressed statuses (awareness); be familiar with how their cultural identity plays out in their personal and professional experiences (knowledge); engage in skill development to communicate, apply, and assess their knowledge (skills); and make changes on a personal and professional level through cultural immersion and professional development opportunities (action). The fourth developmental domain, counseling and advocacy interventions, specifies that social action should occur in six areas—the intrapersonal, interpersonal, institutional, community, public policy, and international levels—to build multicultural counseling competency. The developmental domains are depicted by concentric circles that build upon each other, beginning with counselor self-awareness on the circumference of the innermost circle and culminating in counseling and advocacy interventions just below the circumference of the outermost circle.

The Millers: A Therapeutic Journey

This last part of Chapter 1 offers a brief overview of the extended family of the Millers and a somewhat more in-depth overview of the immediate family (Jake, Angela, Celia, and Luke). At the conclusion of every chapter, you will find a vignette that highlights a member of the immediate or extended Miller family going through the type of therapy you just read about. This is followed by a series of questions relevant to the family member's experience in that therapy. These questions will help you examine basic constructs of the theoretical approach highlighted, review some of the ethical concerns denoted in the chapter, and highlight some of the multicultural concerns we just examined. Make sure that you familiarize yourself with the Millers, so you will have a context from which to understand the struggle with which a particular family member is dealing.

Meet the Millers

- Jake and Angela Miller recently celebrated their 15th anniversary with their friends, parents, and children. Jake's father and mother, Ted and Ann, were there, and they brought Jake's sister, Justine. Ted and Ann met in Atlanta and have been married for 42 years. Ted earned a law degree and has worked in corporate law ever since, while Ann worked as a piano teacher until her twins, Jake and Justine, were born. Jake and Justine are now 41.
- Angela's parents, Dexter and Evangeline, celebrated with the family. Dexter and Evangeline met at college in California 41 years ago. Dexter, whose parents were from Nigeria, is an English professor at a mid-sized private university. Evangeline worked as a social worker facilitating adoptions. Due in part to her work, Evangeline and Dexter eventually adopted two Black children when Angela was five: Lillian, who was just an infant, and Markus, who was two. Angela is their only biological child and is now 40 years old. Lillian is a social worker, married, and has two children. Markus is gay, lives with his partner, and just left his job as a high school English teacher to pursue his PhD in Literature.
- Jake and Angela met in graduate school, and today, Jake works as a structural engineer and Angela is an art teacher at an elementary school. They have two children, Luke (10) and Celia (7). The nuclear and extended family have had a few relatively minor mental health concerns. Recently, however, Jake has had some serious bouts with anxiety which have begun to affect his relationship with his wife and children. The situation has become

so difficult that it has placed a strain on Jake and Angela's relationship. In addition, their growing tensions might be contributing to problems their children recently started to experience at school.

Figure 1.5 provides a genogram of the extended Miller family, and this is followed by a more detailed description of the Jake, Angela, Luke, and Celia, so you can better understand their situation as you read about the immediate and extended family throughout the text.

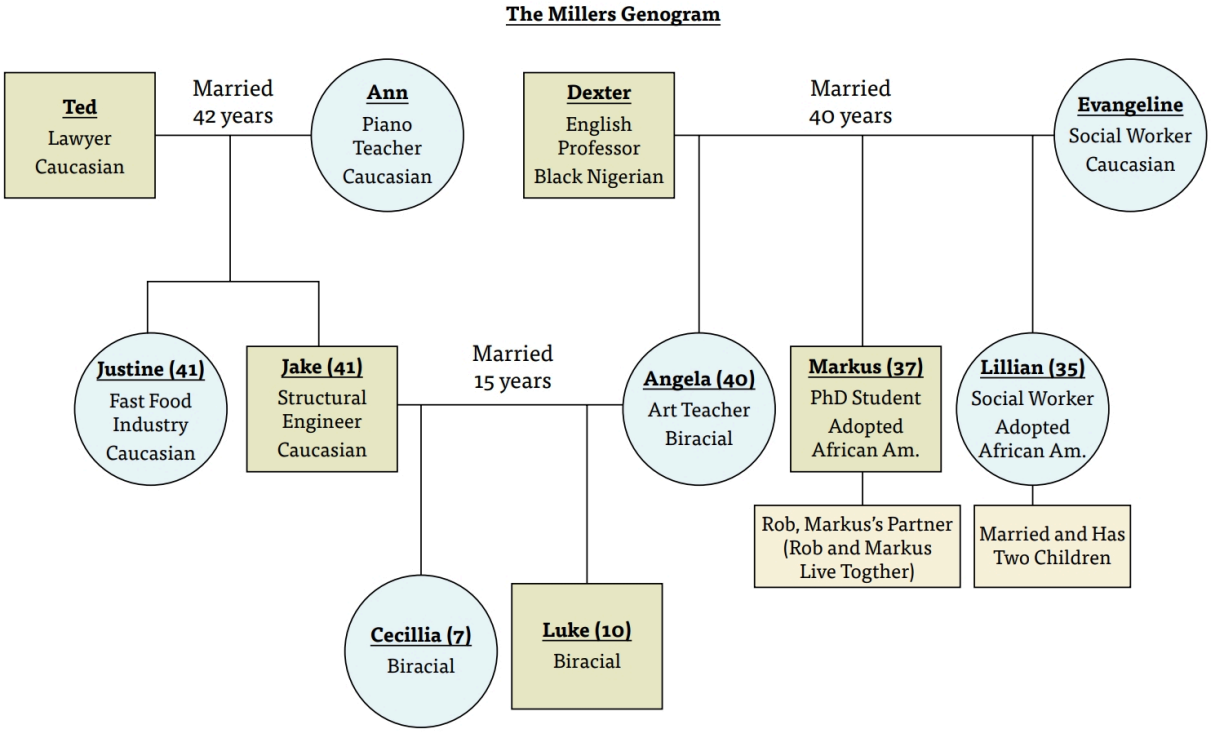

FIGURE 1.5 Genogram of the Miller Family

The Immediate Family Members: Jake, Angela, Luke, and Cecillia

Jake

Until the age of 10, Jake remembers a happy childhood. From what he could tell, his parents, Ted and Ann, got along well. Ann had lots of friends she saw often and was active in the community, and Ted seemed content in his work. Jake describes his childhood like this: "I don't really remember anything *bad* happening when I was a kid. My parents seemed like they had a lot of fun together; they got along well, teased each other—they were affectionate and all that. What stands out for me is how much fun my twin sister, Justine, and I had when we were kids. We were into everything, climbing on the roof of the house or digging holes under the shed until the floor caved in—that kind of thing. There was nothing that Justine would not try; she was funny, real quick, you know, and so brave. Nothing scared her. That was before the accident.

One day Justine got it in her head that we would take Dad's car out of the garage and park it on the other side of the wooded area across the interstate. It was a joke for April Fool's Day. We were

only 10, and of course I was scared, but Justine was sure it would be a good trick, so before I knew it, we were in the car, and I was driving! Justine was laughing; I remember that she had her bare feet curled up under her and, as always, no seatbelt. I guess I didn't look or something 'cause right after I pulled the car out onto the interstate, a semi hit the car and Justine went through the windshield. She was never the same. She was out for a long time, and when she finally came out of her coma, she had a serious brain injury. She had to learn to talk again and all that. When she did talk ... well, she wasn't Justine anymore." Today, Justine is cared for by her parents and can maintain a job at a local fast-food restaurant. However, she continues to have serious cognitive impairment. Although Jake tends to have a good relationship with her, he periodically quips at her telling her he thinks she can do better than she has been doing.

After the accident, Jake began to have problems with anxiety. He had a hard time sleeping through the night and had nightmares. "Things changed a lot at our house. It seemed like no one ever laughed anymore and we didn't *do anything*. Before the accident, my parents would come up with something spontaneous and fun, and we would get up and go! But after Justine changed, well things at the house got real quiet, and I always felt that something bad was going to happen. I was afraid to leave the house sometimes." Jake's parents took him to a psychiatrist briefly to address the nightmares and anxiety, but they did not talk about his feelings together as a family and rarely referred to the accident.

As the years passed, Jake's anxiety lessened, and he was only occasionally disturbed by anxiety or nightmares. He seemed to move on with his life, and he successfully finished high school, college, and graduate school. He met and married his wife while in graduate school. Soon after he married and had children, he became involved with a national association that advocates for child-safe automobiles "just so nothing like what happened to Justine could happen to anyone else again."

Although Jake sounds proud when describing his wife and children, in recent months, he has been struggling with several issues. Jake notes, "We've been having problems with Luke. He's fearless, like Justine was—and always into something! He's not bad, just mischievous, but lately he's been getting in trouble at school. A couple of months ago Luke and Celia were playing in the car, and Luke knocked the car out of park. I was mowing the lawn and came around the corner just in time to see the car roll into the street. I felt my chest tighten; I couldn't breathe. I thought I was having a heart attack!" Since the incident with the car, I am anxious all the time. I can't sleep and when I do, I have nightmares. I have been afraid for Angela to take the car and ... I guess I've been difficult to deal with."

Since the incident, Jake is constantly checking all the locks, making sure the car is in park, and always checking on the children. He has even asked Angela to homeschool the children to make sure that they are safe. He is also aware that his relationship with Angela is different: "Angela and I just seem kind of disconnected lately." Jake has also noted that his anxiety has caused him to miss work lately, and he is concerned he will get a poor performance evaluation.

Angela

Angela is feeling at a loss. One afternoon, while at work, she confided to the school counselor, "I really don't know what is happening to our family. Jake has just gotten so anxious that it is a full-time job keeping up with all his fears. He gets so angry with me for insisting Celia go to school, and Luke just won't listen to him at all. I feel like I'm a character in one of those really bad movie-of-the-week things. Sometimes I go into the bathroom, turn on the water in the tub, and cry. I don't want to live my life this way."

When Angela was growing up, she spent the fall and spring on a university campus and spent summers in Nigeria with her father's family. "I enjoyed spending time with my grandparents,

but somehow, I always felt out of place. When I was in Nigeria, my cousins treated me differently, because as far as they were concerned I was 'White,' and an American, but when I was back in America I was 'Black.' But I really didn't feel 'Black' either. In fact, most of the time, I felt more like a Nigerian kid than an American. You'd never catch me talking to my parents or teachers the way the kids at school talked to adults!

"No matter where we were, there was always one constant, my role as caretaker. Lillian, my adopted sister, was born with a congenital hip deformity that made walking difficult. It was my job to see to Lillian and make sure she had what she needed. I was never free to just go out and play with the other kids. I always had to stay near Lillian. I felt so trapped when I watched the other children on their bikes or playing chase. That's how I feel now; with Jake's demands, I feel trapped watching everyone else live their lives and still, after all these years, not really knowing who I am."

Luke

Luke is 10, and he is starting fifth grade this year. Luke had been a vibrant active little boy since day one. He is curious and bright. His mother, Angela, has delighted in his willingness to try anything. He seems to live life fully and to feel things deeply. His laughter is contagious, but when Luke is angry, he can be difficult to reason with.

Luke's father spends a lot of time trying to rein Luke in, "He's like a wild horse sometimes. He can be so out of control." Luke does not always listen to warnings about safety, like staying out of the car, for instance. If something breaks or someone is hurt, it is often Luke that is at the bottom of it. These incidents make Jake furious. Angela is not comfortable with the way Jake yells at Luke, and lately, they have been fighting over it.

Cecilia ("Celia")

Cecilia is 7 and is going to be in the second grade. Her mother explains, "Right away, we could see a difference between the two children. Celia is much more cautious—an observer. She tends to absorb whatever feeling is around her. She can get caught up in Luke's excitement, and she likes to join Luke in his adventures and pranks. However, she is also a worrier and will sometimes be reluctant in joining Luke in his adventures, which makes Luke angry. A lot of the time Luke and Celia start out playing together but end up in an argument."

Recently, Celia has had problems with anxiety. What began as a mild resistance to going to school has increasingly become a school phobia. Increasingly, her mother gets a phone call from the school nurse saying that Celia has a stomachache and wants to come home. Angela became worried when Celia got so anxious one morning about getting on the bus to go on a field trip that she wet her pants.

The Miller family is not particularly unusual. As they say, into every life a little rain must fall. But things have gotten difficult enough for Jake, Angela, Luke, and Celia that counseling might offer them one way of knowing themselves better and might be a method for the family to find a sense of renewal, while providing a healthier way of living with one another. We hope that as you read about and get to know the Miller family in more detail throughout the text, you will gain an appreciation for how each theory can be helpful for an individual who is struggling with life's issues.

Summary

This chapter began by providing a discussion regarding the differences between counseling and psychotherapy. We, then, examined the research on the overall effectiveness of counseling, noting that regardless of the theory, counseling and psychotherapy have shown to be quite efficacious. We went on to note that some client factors, such as readiness for change, psychological resources, and social supports, affect counseling outcomes and then highlighted what is called evidenced-based practice (EBP), which speaks to the importance of research supported treatments and clinical expertise in positive outcomes. We also spoke to the importance of being able to embrace a number of common factors, such as building an alliance, having empathy, knowing your theory, and being able to deliver your theory if counseling is to be effective.

Next, the chapter moved on to defining "theory" and noted five major forces of counseling and psychotherapy (psychodynamic, existential–humanistic, cognitive-behaviorism, multicultural–postmodernism, and social advocacy). We explained why having a theory, based on one's view of human nature, is critical if one is to be a competent counselor, and we offered some exercises so you could explore your view of human nature. Examining how one builds a theory, we discussed four stages of development toward theoretical integration that many counselors follow as they gain increased expertise as a therapist. These included the chaos, coalescence, multiplicity, and metatheory stages.

The chapter next moved on to a discussion about the importance of ethical codes in delivering your approach, a number of "hot spots" to be aware of when practicing counseling, and four models of ethical decision-making one can use when faced with a thorny ethical situation: problem-solving, moral, social constructionist, and developmental. In addition, we highlighted best practices to identify several ways in which a clinician can lessen mistakes and reduce the probability of malpractice lawsuits.

The chapter, then, examined culturally competent counseling and psychotherapy. We noted the importance of decolonizing counseling theory, which speaks to the importance of understanding the biases that are inherent in many counseling approaches and ensuring they do not negatively impact marginalized clients. We also highlighted the multicultural and social justice counseling competencies, which offers a model to follow when counseling diverse clients. The chapter concluded by introducing the Miller family, and we gave short descriptions of several of the members of the Millers and offered a genogram describing the Millers.

Key Words and Terms

atheoretical eclecticism
autonomy
beneficence
best practices
chaos stage
client factors
coalescence stage
committed in relativism
common factors
counseling
culturally responsive counseling and psychotherapy
culture
decolonizing counseling theory and practice
decontextualized self
developmental models
dualistic perspective
eclecticism
ethical codes
ethics
evidence-based practice (EBP)
external locus
external locus of control
integrative approach
internal locus of control
justice
locus of control
locus of responsibility
metatheory stage
moral models
Multicultural and Social Justice Counseling Competencies (MSJCC)
multiplicity stage
nonmaleficence
paradigm shifts
postmodern
problem-solving models
psychotherapy
reductionist

social advocacy
social constructionist perspective
string theory
theoretical orientation
theory
veracity
view of human nature
worldview

Key Names

Eysenck, Hans
Freud, Sigmund
Kitchener, Karen

CREDITS

Fig. 1.2a: Copyright © 2011 Depositphotos/leremy.
Fig. 1.4: M. J. Ratts, A. A. Singh, S. Nassar-McMillan, S. K. Butler, & J. R. McCullough, "Multicultural and Social Justice Counseling Competencies," https://www.counseling.org/docs/default-source/competencies/multicultural-and-social-justice-counseling-competencies.pdf?sfvrsn=8573422c_22. Copyright © 2015 by American Counseling Association.

SECTION I

PSYCHODYNAMIC APPROACHES

This first section of the book examines three classic and prominent psychodynamic approaches to counseling and psychotherapy: psychoanalysis (Freudian therapy), analytical therapy (Jungian therapy), and individual psychology (Adlerian therapy). Developed near the beginning of the 20th century but maintaining widespread popularity today, these approaches have tended to be long-term, although in recent years some have been adapted and used in relatively brief treatment modality formats. Psychodynamic approaches vary considerably but contain some common elements:

- A belief that the unconscious and conscious affect the functioning of the person in some deeply personal and "dynamic" ways;
- The importance of how distress and resistance is determined by complex, and often unconscious drives and forces;
- A focus on how past experiences with parents and other significant relationships affect the clients' personality development and their experience of the present;
- An exploration of how fears, neurotic behaviors, fantasies, dreams, and other aspects of personality can be rich sources of information about past relationships, drives, and unconscious factors.

Accompanying this text is a video file that provides a roleplay for each therapeutic approach being presented in Chapters 2 through 13. In addition, a separate video file that illustrates an integrative psychodynamic approach with Angela Miller is provided with the book.

2 Psychoanalysis (Freudian Therapy)

Learning Goals

At the conclusion of this chapter, readers will:

- be familiar with the life of Sigmund Freud and the historical context in which he created psychoanalysis
- understand the roles that instincts, drives, personality development, and the unconscious play in the development of Freud's view of human nature
- have knowledge of key concepts of psychoanalytic theory, including consciousness and unconsciousness, drives and instincts, the structure of personality, types of anxiety, defense mechanisms, psychosexual stages of development, and transference and countertransference
- be familiar with major techniques used in psychoanalysis, including ways of creating a trusting atmosphere, analytic neutrality, free association, interpretation of resistance, dream analysis, interpretation of parapraxes, and interpretation of the transference relationship
- understand the long-term counseling process of psychoanalysis
- be able to articulate important social, cultural, and spiritual issues of psychoanalysis
- understand available research the effectiveness of psychoanalysis

In this initial chapter on psychodynamic approaches, we present the major tenets of psychoanalysis. We begin by examining the life of Sigmund Freud, the founder of psychoanalysis, and outline the historical influences that drove his theory. This is followed by a review of major theoretical constructs and an examination of how they influence the therapeutic process. We then share social, cultural, and spiritual considerations as well as efficacy research regarding the practice of psychoanalysis. We conclude the chapter by applying psychoanalytic principles to Jake, a member of the Miller family.

Sigmund Freud

Today, historians rank Freud's scientific contributions with those of Planck and Einstein. He appears on most lists of the greatest physicians in history. He was recently on the cover of Time (with Albert Einstein) for an issue dedicated to the greatest scientific minds of the century and was ranked sixth in a book on the hundred most

> influential scientists. Yet if Freud's fame and influence have continued to grow since his death more than 60 years ago, so have the criticism and the controversy surrounding him. He persists in spite of it all. Freud's photo graces Austrian currency. His ideas remain permanently embedded in our culture and our language.
>
> We use terms such as *ego, repression, complex, projection, inhibition, neurosis, psychosis, resistance, sibling rivalry*, and *Freudian slip* without even realizing their source. Freud's model of the mind is still perhaps the most developed of all. Of the more than 100 forms of psychotherapy, many continue to use one or another of Freud's concepts. Perhaps most important of all, his theories influence how we interpret human behavior, not only in biography, literary criticism, sociology, medicine, history, education, and ethics, but also in law. We now take for granted the basic psychoanalytic concept that our early life experiences strongly influence how we think, feel, and behave as adults. Because of the unmistakable impact of his thought, some scholars refer to the twentieth century as the "century of Freud." (Nicholi, 2002, p. 2)

Armand Nicholi, Jr., Excerpt from: "Prologue," *The Question of God: C.S. Lewis and Sigmund Freud Debate God, Love, Sex, and the Meaning of Life*, p. 2. Copyright © 2002 by Simon & Schuster, Inc.

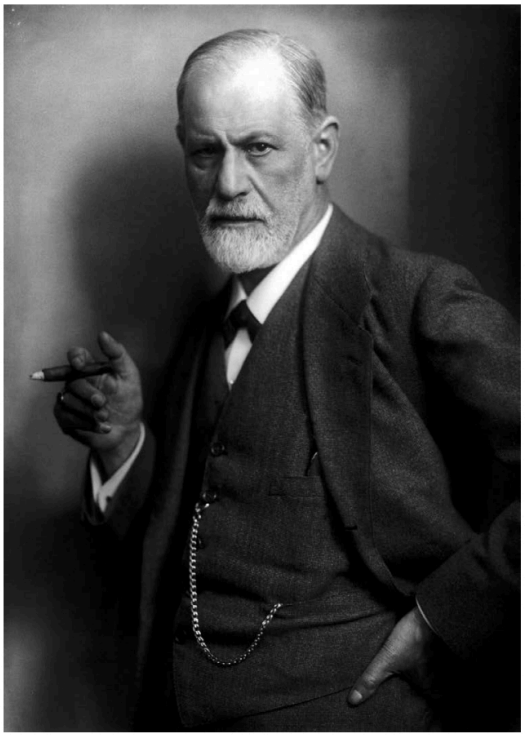

FIGURE 2.1 Sigmund Freud

In this excerpt Nicholi (2002) highlights the substantial influence of Sigmund Freud in counseling and psychotherapy as well as in society today. But who was this individual, considered one of the top scientists of our time?

On May 5, 1856, *Sigmund Freud* was born in what is today known as the Czech Republic. At four, Freud's family moved to Vienna, Austria, for a better life. A Jewish wool merchant, Freud's father was a widower, and his second wife, Amalia, was 20 years younger than him. Freud had two half-brothers from his father's first marriage and was the oldest and favorite of his mother's eight children. His half-brothers were about the same age as his mother, and "Sigi," as his mother liked to call him, was only slightly younger than one of his nephews. This interesting family constellation might have been one of the reasons Freud was so fascinated by how family dynamics affected childhood development. Sensitive and brilliant as a child, it is not surprising that he went to the University of Vienna, where he studied neurology and psychiatry. Eventually, Freud became well-known in the field of neurology—the science and study of nerves and nervous disorders. Although Freud would make a lateral move to the field of psychiatry, he continually assumed there was a large neurobiological component to the development of personality—a component that only in recent years has, to some degree, been validated (McGowan, 2014; Panksepp & Solms, 2012).

In 1885, Freud went to Paris to study with *Jean-Martin Charcot*, who found that when persons with *hysteria* (e.g., anxiety disorders, fainting, muscle spasms, paralysis, dissociation, and a variety of other symptoms) were placed under deep hypnosis, their symptoms would often be relieved (see Figure 2.2). Hysteria was particularly common in women and seen as an organic (physical) disease that was associated with sexual frustration (Hopkins, 2015):

> For thousands of years, women's health complaints were often diagnosed as "female hysteria"—a catch-all term that basically implied "it's all in her head." The condition was believed to be caused by a wandering uterus and/or sexual frustration. Doctors

FIGURE 2.2 One Early Form of Hypnotic Suggestion

treated the condition using various regimens. Sometimes they would prescribe treatments with herbs and cold water. They also advised patients to go horseback riding, use a vibrator, or have regular sexual encounters with their husbands. Should those cures fail, the insane asylum was always an option. (Lines, 2020, para. 1)

Although Freud viewed sexual drives as a major factor underlying mental disorders, the fact that he viewed hysteria as a psychological disorder and eventually treated such symptoms with *talk therapy* was seen as revolutionary and changed the manner in which disorders would be treated (Hopkins, 2015).

After returning to Vienna in 1886, Freud married *Martha Bernays*. The couple had six children with his youngest, *Anna Freud*, becoming a well-known child psychoanalyst. During the late 1880s, Freud set up his own private practice using hypnotic suggestion as his primary technique. At the time, many saw hypnosis as having the ability to cure a large range of diseases, from constipation and deafness to mental illness (Hopkins, 2015).

In 1887, Freud befriended *Wilhem Fliess* (1858-1928)—an ear, nose, and throat specialist, who believed that due to similarities between nasal and genital tissue, nose surgery could treat a number of disorders he thought were fueled by sexual frustration (Breger, 2009). Although beginning to develop his own approach with clients, Freud was fascinated by Fliess's theory of *nasal reflex neuroses*, and he was particularly interested in the possible relationships between the nose, sexuality, and hysterical symptoms. As a result, Freud started to refer some of his own patients[1] to Fliess to have surgery on the nose to help cure them of their hysterical symptoms.

Fliess became Freud's confidant, and the two were soon sharing esoteric ideas about the nature of being (Breger, 2009). A proponent of the use of cocaine to cure a host of diseases, Fliess influenced Freud to experiment with the drug; Freud later struggled to break free of a cocaine addiction he developed. Eventually, as Freud's ideas about the origins of symptoms and their relationship to sexuality changed so did his relationship with Fliess, and their friendship would eventually end.

From 1893 through 1896, Freud worked on documenting case histories with his colleague *Josef Breuer* (1842–1925), who, like Charcot and Fliess, was trying to understand the development of hysterical symptoms in patients. One patient, a 21 year old named *Anna O.*, intrigued the two curious physicians. Anna had come to Breuer with hysterical symptoms, including paralysis of limbs; unusual eye movement; problems with vision; difficulty maintaining her head in a suitable position; nausea; difficulty drinking despite being thirsty; and problems with speech, confusion, and delirium (Freud, 1910). Having been treated unsuccessfully by several doctors, many of whom believed she was faking her symptoms, from 1880 to 1882 Breuer treated Ann much more caringly than her past doctors. Through hypnosis and early attempts at free association (saying whatever comes to mind), Anna was encouraged to talk about several underlying

1. Freud and other psychoanalysts of his time used the word "patients," and some contemporary analysts still do. However, the word has come into disfavor in recent years due to its association with the medical field and its air of aloofness. For convenience, this chapter will generally use the word "clients."

issues, which, Breuer hypothesized, were partially causing her symptoms. Eventually, Breuer believed that Anna blamed herself for the death of her father, whom she had cared for, and that she unconsciously caused her paralysis as a form of punishment. Through talk therapy, she was able to release emotionally blocked aspects of herself. The importance of experiencing this *catharsis* or *abreaction* eventually became a critical tenet of many subsequent therapies, including psychoanalysis.

Breuer worked tirelessly with Anna, often seeing her twice daily and putting 1,000 hours into her treatment (Gilhooley, 2002). As Breuer continued to see Anna, he realized she had become dependent on his presence, and her mental health seemed correlated with his being there for her. Initially captivated by Anna, Breuer later became overwhelmed by her, and some suggest that he became so distraught over her ongoing symptoms and insatiable needs that he turned to giving her psychotropic drugs to reduce her dependency on him. Partly out of frustration, Breuer eventually transferred her to a sanatorium. Although controversy about this case continues, most people suggest it shows the power of transference and countertransference (discussed later in this chapter). Despite treatment problems, it is likely that Breuer's therapy was a first step toward Anna's mental health: Anna, later revealed to be *Bertha Pappenheim*, became a writer and early feminist and is often identified as one of the first social workers in Germany.

As a result of the work with Anna, in 1895 Freud and Breuer published *Studies in Hysteria* (1895/1974). Charcot, Fliess, and Breuer influenced Freud's developing theory, which became the first comprehensive theory of counseling and psychotherapy. Some of their influences include the development of concepts such as neurosis, the unconscious, free association, defense mechanisms, transference and countertransference, resistance, and dream analysis.

As Freud continued to experiment with different techniques, he eventually discontinued the use of hypnosis, as he found that some patients could not be hypnotized and that its resultant "cures" were often only temporary (Hopkins, 2015). As Freud increasingly became interested in the relationship between sexuality and symptoms, he tried a new technique of pressing on clients' foreheads and encouraging them to reveal repressed memories, as he revealed in a letter written to Fleiss in 1895:

> I have invented a strange therapy of my own: I search for sensitive areas, press on them, and thus provoke fits of shaking which free [the patient]. (Masson, 1985, p. 120)

Through extensive talk therapy with his female patients, Freud came to believe that many of them had been molested at a young age by their fathers. These revelations led to the development of his *seduction theory*, which suggested that early childhood sexual trauma was the cause of many of the symptoms exhibited by his patients. However, Freud eventually abandoned this theory for one in which memories of early sexual trauma were seen as fantasy, often in an effort to repress memories of early masturbation (Hopkins, 2015).

In 1895, Freud published *The Interpretation of Dreams* (Freud, 1899/1976a), in which he first suggested that dreams represent underlying unresolved concerns and desires. On the basis of this and later publications, his career took off. In particular, his 1901 book, *The Psychopathology of Everyday Life*, began to gain much popularity and some notoriety due to its compilation of *slips of the tongue*, which could be quite funny at times. In 1902, Freud was appointed as an associate professor at the University of Vienna. In 1905, he published *Three Essays on the Theory of Sexuality*, which described the *psychosexual stages* of development and an explanation of what was to be commonly known as the *Oedipus complex* (Freud, 1905/1976b). In 1908, Freud founded the Viennese Association of Psychoanalysis, a predecessor to the many psychoanalytic societies found throughout the world today. Freud influenced and mentored dozens of early psychoanalysts, many of whom became well-known psychoanalysts and some of whom, like *Carl Jung*, *Alfred Adler*, and *Otto Rank*, eventually became disillusioned with Freud and went on to develop their own well-respected theories.

Over the years, Freud wrote a number of other well-known and revered works that expanded on his theory, such as *Totem and Taboo* (1913/1950), *Introductory Lectures on Psychoanalysis* (1917/1973), *Beyond the Pleasure Principle* (1920/1961a), *The Future of an Illusion* (1927/1961b), and *Civilization and Its Discontents* (1930/2005).

As Freud continued to develop his ideas, he increasingly used the word *neurosis* to describe nervous symptoms that had no obvious organic basis. He believed that the unconscious—the hidden, secretive, part of ourselves—hides our desires, fantasies, and wishes, which are the causes for our neuroses. Freud was not immune to the neuroses he talked about, as he struggled with anxiety, depression, psychosomatic symptoms, a fear of trains and traveling, superstitious beliefs about numbers (e.g., the year he might die), and generalized fears of dying (Breger, 2009; Gay, 2006). Through self-analysis, he explored his memories and dreams and came to recall sexual feelings toward his mother as well as feelings of anger and hostility toward his father. These memories, and his own sexual repression, likely led to the development of his famous Oedipus complex, which formed the basis for his ideas on childhood sexuality and an understanding of the superego. He was, for a short time, addicted to cocaine, twice destroyed his personal papers believing they were worthless, and often went into tirades when colleagues disagreed with him (Gay, 2006; Jacobs, 2003). Freud also likely had an affair with his wife's sister, *Minna Bernays*, who lived with the Freuds (Mack & Kaufman, 2013). In 1938, with anti-Semitism growing in Austria and Europe and following the Nazi invasion of Austria, Freud fled to London. In 1939, following a 15-year battle with cancer of the jaw, Freud asked a physician friend, Dr. Schur, to assist him in suicide.

> My dear Schur, you certainly remember our first talk. You promised me then not to forsake me when my time comes. Now it's nothing but torture and makes no sense any more. ... I indicated that I had not forgotten my promise ... When he was again in agony, I gave him a hypodermic of two centigrams of morphine. He soon felt relief and fell into a peaceful sleep. I repeated this dose after about twelve hours. Freud was obviously so close to the end of his reserves that he lapsed into a coma and did not wake up again. He died at 3:00 A.M. on September, 23, 1939. (Schur, 1972, p. 529)

BOX 2.1 Want to Meet Sigmund Freud?

Want to hear a brief biography about Freud from the man himself and find other tidbits of information about him? Go to https://silver.odu.edu/psyadm/ to see a caricature of Freud talking about himself and his theory. Click on the psychodynamic door, and go into Freud's office.

Undoubtedly, Freud was a brilliant man of great complexity, who changed the way people came to understand their existence (Makari, 2008). Clearly, Freud was a man who struggled in his own life with unconscious desires and the demons associated with them. Assuredly, Freud was a person who changed the understanding and treatment of mental disorders and who brought us a new paradigm of understanding the individual (see Box 2.1).

View of Human Nature

Developing his theory at the turn of the 20th century, Freud was immersed in the world of *modernism*, where science, objectivity, and the search for knowledge and truth took precedence over mystical beliefs and religious dogma (Brenkman, 2004). Freud sought to uncover scientific causes of neuroses, informed by Charcot and Breuer's experimentation with hypnotism and Fliess's theory of nasal reflex neurosis.

Freud believed that humans are motivated by *instincts*, sometimes called *drives*. This innate *psychic energy* comprises what is called the *id* and steers behavior toward the satisfaction of unmet needs (e.g., hunger, thirst, survival, and sex). However, because instincts are indiscriminate about the attainment of those needs, Freud postulated that restraints must be placed on

the individual through the development of higher-order cognitive processes, which he called the *ego* and *superego*. Otherwise, individuals would respond in animalistic ways, and the world would be chaotic, at best.

Finding acceptable ways of satisfying our instincts, or resolving the tension of conflicting instincts, are mostly unconscious processes. These instincts, Freud asserted, could be detected through dream analysis, by slips of tongues, by understanding how our defense mechanisms manage our instincts, and by understanding how our neuroses and psychoses, manifested through symptoms, are representative of our unsuccessful attempts at redirecting instincts. Because the majority of time we spend unconsciously struggling to satisfy our unmet needs, Freud believed that happiness was an elusive feeling experienced infrequently and that we were destined to often be discontent:

> One feels inclined to say that the intention that many should be 'happy' is not included in the plan of 'Creation'. What we call happiness in the strictest sense comes from the (preferably sudden) satisfaction of needs which have been dammed up to a high degree, and it is from its nature on possible as an episodic phenomenon. ... Thus our possibilities of happiness are already restricted by our constitution. Unhappiness is much less difficult to experience. (Freud, 1930/2005, p. 53)

Freud hypothesized that, from birth, instincts impinge on the person, and early child-rearing practices mold how individuals manage those instincts. Thus, he noted that poor parenting results in behaviors that are not particularly effective in the management of instincts and is the main reason one becomes neurotic or even psychotic. Therefore, the structure of personality is developed in early childhood and is largely unconscious, making personality changes later in life a monumental task. Thus, his theory is often considered *deterministic*—meaning our personalities are framed for us early in life and are quite difficult to change.

Freud suggested that our understanding of the world, or our *psychic reality* (Barratt, 1984; Meissner, 2001), needs to be distinguished from *objective reality*, which is external to the person yet difficult to "know," as each person lives mostly within their own psychic reality. It is only through psychoanalysis that one can better understand their motivations and, perhaps, operate a little more from an objective reality. Using the *tip-of-the-iceberg* analogy (see Figure 2.3), Freud suggested individuals have the capability of better understanding their personality through psychoanalysis.

The paradox of Freud's theory is that humans create society, which naturally places restraints on behaviors in an attempt for all of us to live in peaceful coexistence. However, those very restraints are rebelled against by the id, as it tries to get its needs met. Thus, the ego and superego must find ways to defend against the id taking control, and it is those very defense mechanisms that can result in neurotic or even psychotic behaviors. However, there is some hope, as we can gain a slightly increased understanding of our behaviors through therapy and self-analysis.

Key Concepts

Some of the key concepts that underlie psychoanalytic theory include consciousness and unconsciousness; drives and instincts; the structure of personality, including the id, ego, and superego; anxiety, including realistic, moral, and neurotic anxiety; defense mechanisms; psychosexual stages of development, including the oral, anal, phallic, latency and genital stages; and transference and countertransference.

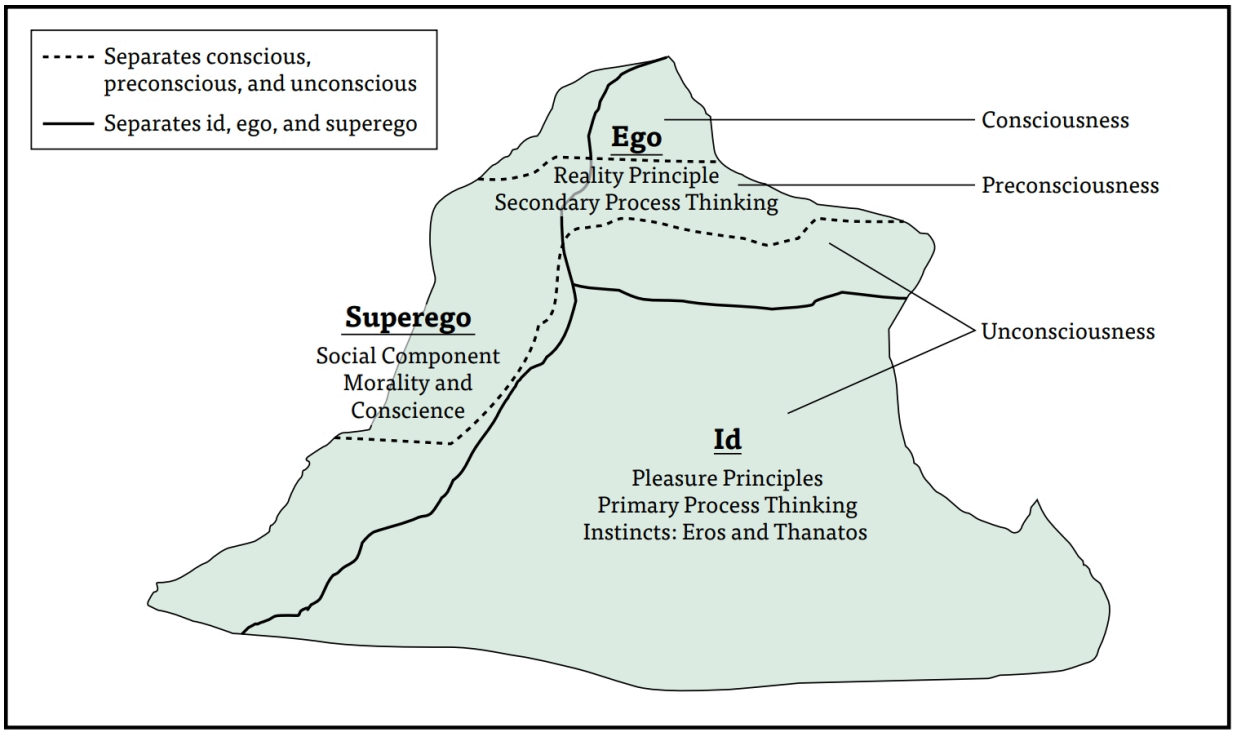

FIGURE 2.3 The Tip of the Iceberg

Consciousness and Unconsciousness

Consciousness, or all of our feelings, thoughts, fantasies, and behaviors of which we are aware, is a small part of what Freud believed motivates the individual. The *unconscious*, or more primitive mind, however, is where our underlying desires and wants that motivate our behavior are contained. Representing the largest portion of self, the unconscious houses our psychic energy, which is comprised of our instincts, often referred to as our id (see Figure 2.3). In addition, the unconscious is where repressed material and memories that hold a strong negative emotional charge are stored. In contrast, those parts of ourselves that are relatively close to consciousness, but not in awareness, are in the *preconscious*. The preconscious houses all memory that has been lost to consciousness but can be accessed and remembered with relative ease (Freud, 1917/1973). The goal of psychoanalysis is to make a greater part of the unconscious conscious, so the individual can gain an increased understanding of self and more control over primitive urges and desires.

Drives and Instincts

Freud suggested that we are born with a coexisting *life instinct* (*Eros*) and *death instinct* (*Thanatos*). The life instinct operates to meet our basic need for love and intimacy, sex, and survival of the individual and the species. It is associated with cooperation, collaboration, and harmony with others. The death instinct is a drive that seeks our own demise and dissolution. In an evolutionary fashion, we came from nothing, and we will become nothing once again; thus, Freud suggested that the "the aim of life is death" (Freud, 1920/1961a, p. 32). He believed that fear, hate, self-destructive behaviors, and aggression toward others (death instinct projected outward) reflects the death instinct. Freud called all the psychic energy that drove the life and death instincts the *libido*,

although the word has often been associated solely with the sex drive. Freud postulated we are at our best when our life and death instincts are in balance (see Box 2.2).

BOX 2.2 Your Hidden Death Instinct

Have you had thoughts of suicide, participated in unprotected sex, driven too fast or erratically, smoked cigarettes or vaped, drank too much alcohol, harmed your body (e.g., cutting), ate too much or restricted your eating, eaten unhealthily, or taken part in risky behaviors? Do you get a thrill out of watching a football game, hockey game, or boxing match; get angry at others for petty reasons; had thoughts of harming others; jokingly told someone you wanted to "kill them"; had road rage; wanted revenge; or wanted to go to war? All of the above feelings, thoughts, and behaviors are evidence that your death instinct is alive and well.

Why do people participate in behaviors that are harmful and reckless, feel joy from observing violence, or harm or kill themselves or others? Freud said that our death instinct, usually well camouflaged, is at play. It is the part of us that seeks our own demise. Sometimes, it's directed at ourselves, and sometimes it is projected outward toward others, but in either case, it is a destructive force we have all learned to manage—some of us better than others.

What can we do with our death instinct? At best, we can acknowledge and understand it—then find healthy ways to manage it. Ideally, our death instinct can be managed and allowed to live side by side with its antithesis—the life instinct.

By their very nature, instincts are raw, have no conscience, and are largely unconscious. Consequently, we must find ways to restrain them if we are to live in a civilized world. This is accomplished through the development of higher cognitive functions, such as the formation of the ego and superego. It is the ego that helps us find outlets for our libido, such as working to make money to buy food and shelter, loving someone to satisfy our need for intimacy and sex, the watching of and participating in sports events to manage our aggressive and self-destructive tendencies, and the finding of creative outlets to channel different aspects of our psychic energy (e.g., an artist's painting of erotic symbolism). It is the superego that causes us to feel shame and guilt over our impulses and redirects us toward our ego to find acceptable outlets for those impulses.

Structure of Personality

Considered one of the early proponents of a theory of child development, Freud suggested that personality is powerfully affected by how early parental influences manage the development of three *structures of personality*: the id, ego, and superego (Bishop, 2015).

The Id

Psychic energy from our life and death instincts comprises the *id*—or, more literally, "the it." We are born all id, and Freud believed that the id, sometimes called the *primitive mind*, unconsciously motivates almost all of our behaviors (see Figure 2.3). The id operates from raw, irrational impulses, called *primary processes*, and is fueled by *the pleasure principle*, which aims to reduce tension through the simplest means possible. Although tension reduction is sometimes achieved through the acquisition of the need-satisfying object (e.g., breast, food, or person with whom to have sex), oftentimes the object is not immediately available—thus, the development of the ego and superego, which help the psyche find alternative mechanisms for dealing with this tension. Imagine what kind of world we would live in if we had no mechanism for curbing our id (see Box 2.3).

BOX 2.3 Polymorphous Perversion

Freud believed our sexual instincts are raw and directionless at birth and that early parenting roles shaped the emerging ego and superego, which redirects psychic energy from the sexual instincts, so we were not constantly living in a state of sexual arousal. Thus, at birth, our sexuality could be expressed in any manner that would be pleasurable—and any part of the body could provide sexual gratification. This was what he called *polymorphous perversion*. Those individuals who did not successfully manage their sexual instincts through healthy ego and superego development, Freud stated, would end up with one of five perversions:

> What in the adult life is described as "perverse" differs from the normal in these respects: first, by disregarding the barrier of species (the gulf between men and animals), secondly, by overstepping the barrier against disgust, thirdly that against incest (the prohibition against seeking sexual satisfaction from near blood-relations), fourthly that against members of one's own sex and fifthly the transferring of the part played by the genitals to other organs and areas of the body. (Freud, 1973/1917, p. 245)

Although we still hold to sexual prohibitions on bestiality and incest, other aspects of what Freud called perverse (being gay, lesbian, bisexual, pansexual, etc.) is seen today by most people as varied and normal responses to human sexuality.

The Ego

By default, the *ego* owes its development to the id because without an id, the ego has no function. Called the "I" by Freud, the ego develops sometime after the infant is born as the child begins to wrestle with the external world of reality. Partly conscious, but also operating out of the preconscious and unconscious (see Figure 2.3), the manner in which the ego functions is often called *secondary process* (created secondarily after the id has formed). The ego's main function is to temper the id by finding socially acceptable ways of meeting the needs of the demanding id. Thus, the ego is often said to be operating from the *reality principle*. The ego's functioning can be complex because while it initially deals solely with the demands of the id, it also has to respond to the demands of the developing superego, which are generally in conflict with the id's instinctual desires. How an individual resolves the conflict between the id's desire for immediate gratification and the superego's press for moral behavior is said to reflect the individual's *character*.

The Superego

Freud postulated that the *superego*, developed in the first few years of life, was the internalization of the moral imperatives of our parents and other significant others and led to the development of a personal conscience. Freud believed that the superego emerged from the individual's Oedipal struggle, where the individual is desirous of the parent of the opposite sex and wants to eliminate the same-sexed parent. Realizing that this is not a possibility, the individual comes to grips with the fact that instincts must be constrained. How are they constrained? They are housed through our moral imperatives—which are housed in our superego. "Thou shall renounce incestuous desires and thou shall not kill!" says the superego. Without a conscience, we would be all id, living in a chaotic and animalistic world run by our instincts as we attempted to stake out our territory and satisfy our needs (Freud, 1961c/1927). Operating largely out of the unconscious and preconscious, it is often said that the major function of the superego is to "control the beast within"

(see Figure 2.3). Consider the largely unconscious struggles a person goes through as they are driven to meet their needs (the id), that they are periodically reprimanded for having such needs (the superego), and they struggle to find socially acceptable ways of satisfying those needs (the ego). At the same time, consider the importance of the id, allowing us to have fun, be creative, be spontaneous, and "let loose"; of the superego assisting us in laying a foundation for living in a moral world; and of the ego helping us to balance these two contrasting aspects of ourselves. In the end, a healthy ego will mitigate the harshness of the superego and manage the energy of the id as the individual learns how to live in a relatively civilized world, despite the many internal conflicts that exist (see Box 2.4).

BOX 2.4 Why War?

Freud believed our intellect was one way that people could live in peaceful coexistence. However, he undoubtedly felt this would be a difficult process, as our death instinct is powerful. You can see his limited hopefulness concerning peace in this letter he wrote to Albert Einstein (Freud, 1931–1932, as cited in Nathan & Norden, 1960):

> I now can comment on another of your statements. You are amazed that it is so easy to infect men with the war fever, and you surmise that man has in him an active instinct for hatred and destruction, amenable to such stimulations. I entirely agree with you. I believe in the existence of this instinct and have been recently at pains to study its manifestations. (pp. 196–197)
>
> On the psychological side two of the most important phenomena of culture are, firstly, a strengthening of the intellect, which tends to master our instinctive life, and, secondly, an introversion of the aggressive impulse, with all its consequent benefits and perils. Now war runs most emphatically counter to the psychic disposition imposed on us by the growth of culture; we are therefore bound to resent war, to find it utterly intolerable. With pacifists like us it is not merely an intellectual and affective repulsion, but a constitutional intolerance, an idiosyncrasy in its most drastic form ...
>
> How long have we to wait before the rest of men turn pacifist? Impossible to say, and yet perhaps our hope that these two factors—man's cultural disposition and a well-founded dread of the form that future wars will take—may serve to put an end to war in the near future, is not chimerical. But by what ways or byways this will come about, we cannot guess. Meanwhile we may rest on the assurance that whatever makes for cultural development is working also against war. (pp. 201–202)

Anxiety

Freud realized that the complexities inherent in the development of the id, ego, and superego, as the individual tries to master living in the world, naturally lead to a life that is burdened with some amount of anxiety (Bishop, 2015; Feist et al., 2020). More specifically, he identified three kinds of anxiety (realistic, moral, and neurotic), and our ability to manage our anxiety is related to the effectiveness of our defense mechanisms (discussed next).

Ever walk down a dark street alone at night in a part of town noted for its crime? Get nervous? Well, you should. You could get mugged—or worse. This is *realistic anxiety*, and Freud said that it is important for our ego to experience this kind of anxiety, so one might take reasonable action to make it go away.

BOX 2.5 Identifying Realistic, Moral, and Neurotic Anxiety

We all have experienced realistic, moral, and neurotic anxiety. With that in mind, consider times when you might have experienced these types of anxiety and write down short descriptions of what was going on and how the anxiety fit into one or more of these areas. Then, for those who feel comfortable, share in class some of those times that you had such an experience.

Ever think about or do something that compromised your value system or thought or did something that you believed to be against your moral beliefs? Such *moral anxiety* is an important message about how we are living in the world. Originating from the superego, moral anxiety is a fear of violating our own moral beliefs and tells our ego that we are having thoughts and behaviors that are unacceptable to our developed conscience.

Ever feel an urge to harm someone or think about doing something that would not be condoned by society, then become anxious about having felt that way? Such *neurotic anxiety* involves the id trying to take control, is often counteracted by the superego ("thou shalt not do that"), and is an important message to one's ego that steps need to be taken to ensure that the id does not take over (see Box 2.5).

Defense Mechanisms

The ego is in a difficult position as it attempts to fend off anxiety caused by strong urges from the id, demands from the superego, and real and perceived fears that we face or harbor. To protect the ego from anxiety, Sigmund Freud, and later his daughter Anna Freud (1936/1966), identified several defense mechanisms that unconsciously help the individual cope with anxiety. *Defense mechanisms* are healthy when they assist the individual in functioning in adaptive ways in society; however, they become pathological when they are overused and result in behaviors that impair everyday living. Consider the young child who skips along the sidewalk trying not to step on the lines, singing, "step on the crack and break your back." This child's repetitive skipping may be binding the child's anxiety as they begin to realize that life is filled with some real fears—better to focus on skipping than focus on one's fears! However, what if these fears continue into adulthood? The adult who feverishly tries to stop stepping on the cracks may seem a bit odd. Instead, adults will find other ways to bind their anxiety. Box 2.6 offers a partial list of some of the more well-known defense mechanisms. As you read this list, think about what drives may be impinging on the person to create the defense mechanism and to what anxiety the defense mechanism is responding. In what ways can the defense mechanisms be adaptive or maladaptive, and which of these defense mechanisms have you used to ward off anxiety?

BOX 2.6 Defense Mechanisms

asceticism: the repudiation of needs in an effort to deny urges and desires. Example: The anorexic is not only denying themself food but also their sexual impulses.

compensation: the replacement of a perceived weak behavior by a perceived strong behavior. Example: A man becomes a bodybuilder because he feels inadequate as a conversationalist with women.

denial: not admitting that something has occurred. Example: The parent who refuses to admit that his child was molested.

displacement: redirecting an unacceptable impulse to a more acceptable object or person. Examples: An individual who has sexual urges toward a sibling becomes involved with computer sex. Or murderous feelings toward one's parent become enraged feelings toward a political figure (e.g., the president).

dissociation: the removal of oneself from feelings to delay experiencing those feelings. Example: A rape victim dissociates during the violent act in order to separate self from the fear and rage within.

humor: using comic relief to defer feelings. Example: After hearing that she needs a mastectomy for advanced breast cancer, the woman says to her friend, "Well, at least I won't be viewed as a sex object any longer!"

idealization: overstating and overestimating the value of an object or a person to deny negative feelings toward that person. Example: A husband who is often criticized by his wife states, "My wife—she is the best person ever—she's bright, gorgeous, kind, and just perfect!"

identification: associating with certain individuals or groups to affiliate with specific values and deflect underlying feelings. Example: An individual becomes caught up with the Virgin Vow Ministries, which professes the importance of remaining a virgin until marriage.

intellectualization: concentrating on the intellectual components of a situation in an effort to distance oneself from the anxiety-provoking emotions associated with the situation. Example: A person who has just been diagnosed with a virulent form of cancer wants to know all about the science of the disease.

introjection: identifying with an idea so completely that you accept it with little question. Example: The religious zealot who never questions her parents' or church's views on religion. This has the result of not having to fear certain of life's ambiguities or uncertainties (e.g., death).

projection: attributing unacceptable qualities in others that the individual actually has. Example: An individual calling a coworker "judgmental and bossy," when the individual actually acts in that manner and has urges to tell others how to act.

rationalization: the cognitive distorting of events to make them more acceptable with the implication being that there are good reasons for some unacceptable actions. Example: A parishioner says, "Our minister didn't harm anyone; he just had an affair—so what if she was married? The way he was treated after his wife died, you can understand why he would have an affair with someone who was putting herself out there."

reaction formation: the replacing or conversion of an unacceptable impulse into an acceptable one. Example: An individual who has strong attractions to the same sex becomes virulently anti-gay and protests same-sex marriage.

regression: reverting to behavior from an earlier stage of development. Examples: A 10 year old suddenly starts to wet his bed after he discovers his parents are getting divorced. Or after losing his job, a 50 year old becomes overly dependent on his wife.

repression: pushing out of consciousness threatening or painful thoughts. Example: The individual who does not allow themself to remember being molested.

somatization: converting strong feelings or impulses into physical symptoms. Example: An individual's fear of his sexuality is converted into hypochondriacal symptoms.

splitting: viewing people or objects as "all bad" or "all good." Example: "Guns are horrible killing machines," or "My coworker is evil—she is just out for herself."

sublimation: the channeling or refocusing of unacceptable impulses into socially accepted forms of behavior. Example: A person struggling with extreme anger becomes a butcher or boxer, or a person's sexual energy is channeled into creative and artistic endeavors.

suppression: the act of pushing conscious thoughts into the preconscious because they are too anxiety evoking. Example: The "good wife" who has thoughts of having an affair with a neighbor's husband pushes those thoughts out of consciousness.

undoing: performing ritualistic or magical gestures to undo a behavior for which one is feeling guilty. Examples: Following a woman's passionate lovemaking, she always has to clean the house. Or after spanking his children, a father takes them out for ice cream.

Psychosexual Stages of Development

Freud had a unique and complex theory of how a child's libido, or psychic energy, is dispersed through specific *psychosexual stages of development*. He postulated that as the child grows, psychic energy becomes focused on differing *erogenous zones* that correspond to the unfolding biological development of the child (Bishop, 2015). First, the child receives pleasure through the mouth, then the anus, and, finally, the genitals. As the child develops, the way needs are met relative to the erogenous zone being focused upon will affect later personality development. When a child is overindulged or frustrated during a stage, their libido becomes locked or *fixated* at that stage. In other words, the child will have unfinished psychological issues related to that stage and resort to childlike behaviors that are reflective of the unresolved stage. In contrast, the child whose libido is properly dispersed through a stage will continue to the next stage with less difficulty. The five stages, as identified by Freud, include the oral, anal, phallic, latency, and genital stages.

- **stage 1—oral stage:** From birth to around 18 months of age, the infant's erogenous zone is the mouth, and pleasure is found through sucking, eating, and biting. Problems with early feeding through neglect and abuse can lead to adults who seek to complete their missing oral gratification. They may do this by becoming dependent on others, by smoking or drinking too much, by overeating, by over talking, and so on. On the other hand, children who have been overindulged may become needy, demanding, and upset, as they constantly expect their needs to be coddled (the stereotypic problem for Millennials). Still others may develop an oral aggressive personality because of problems during teething. These individuals may become verbally aggressive, argumentative, dogmatic, sarcastic, and so forth.
- **stage 2—anal stage:** Obtaining control over bowel movements is a major task of this stage, which occurs between ages 18 months and three years. Here, tension between the child's desire to obtain pleasure through the expulsion of feces and the child's need to please parents who are teaching the child how to control this important bodily function is high. The conflict between wanting to recklessly expel feces and appropriately going to the bathroom can have far-reaching implications. Parents who are particularly lenient may raise children who have an *anal expulsive* personality and tend to be messy, cruel, sloppy, disorganized, reckless, careless, defiant, and, perhaps, overly generous. However, parents who are particularly strict and use punishment and humiliation in potty training will have children who have an

anal retentive personality. These children tend to be stubborn, perfectionistic, neat, precise, orderly, careful, stingy, withholding, obstinate, meticulous, and passive–aggressive. As you might well imagine, this stage also has implications for how individuals deal with issues of authority and control, both as children and adults.

- **stage 3—phallic stage:** Experiencing pleasurable genital sensations is a major focus during this stage, which occurs between ages three years and five or six years. Here, children will self-stimulate (masturbate) and have a fascination with bodily functions and, as you might expect, be particularly influenced by the moral imperatives of their parents. As children begin to have sexual genital feelings, Freud posited that there is an unconscious libidinal desire to possess the parent of the opposite sex and eliminate or kill the parent of the same sex. Most boys will desire their mothers, and since dad is the obvious obstacle to mom, a boy's natural aggressive instincts will want to get rid of dad. Thus, we see Freud's development of the *Oedipus complex*, or desire to sleep with or possess one's mother and kill one's father, as in the Greek story of King Oedipus, who unknowingly killed his father and married his mother.

  With a boy's realization that some people don't have a penis (e.g., his mother!), he develops an unconscious fearful fantasy, called *castration anxiety*, which is the fear that his father will castrate him to rid him of his sexual desires for his mother (and make him like his mother). Resolution occurs through the son's repression of his feelings for his mother, as he realizes he is no match for his father. At this point, the son has no choice but to identify with his father and displace the sexual feelings he has toward his mother to girls and later to women. This identification leads to internalization of male sex roles behaviors as the son joins the "club" of men.

  Freud was much vaguer on a similar process for women (Scott, 2005). Eventually known as the *Electra complex*, this developmental process is characterized by the girl's realization that she lacks a penis and her unconscious belief that she must have been castrated. Thus, she sees her genitals as wounded and inferior. She subsequently desires a penis of her own, and when she realizes she will not have a one, her *penis envy* is eroticized through a desire for her father and the wish for a child by him. In essence, she wants to "take in" his penis, so she has one of her own. Feeling rebuffed by her father, the young woman has no choice but to identify with her mother and replace her erotic desire for her father for other, more appropriate men—still hoping to have a child to substitute for the missing penis. Freud believed that women go through life feeling lacking, which manifests itself in passive role taking and feelings of competitiveness with men. Today, Freud is believed to have had a culturally encapsulated view of men and women (consider the role women had at that time in history!) and has been justifiably criticized by feminists and others for his belief that women can never fully resolve their inherent conflicts—or that they had them to begin with (Bishop, 2015; see Box 2.7).

BOX 2.7 What if Sigmund Was Phyllis?

Although Freud has been accused of being sexist, perhaps the epitome of this criticism came from an essay Gloria Steinem (1994) wrote, entitled "What If Freud Were Phyllis?" Mimicking Freud's ideas but using a woman's perspective, here are some excerpts of the comedic, yet stinging, rebuke of Freud's notion on the developing person:

> All life begins as female, in the womb as elsewhere (the only explanation for men's residual nipples), and penile tissue had its origin in the same genital nub, and thus retained a comparable number of nerve endings as the clitoris. But somewhere along

> the evolutionary line, the penis had acquired a double function: excretion of urine and sperm delivery. Indeed, during the male's feminine, masturbatory, clitoral stage of development—before young boys had seen female genitals and realized that their penises were endangered and grotesque compared to the compact, well-protected aesthetically perfect clitoris—it had a third, albeit immature, function of masturbatory pleasure.
>
> It was almost as if Father Nature himself had paid "less careful attention" to the male. (pp. 50–51)
>
> Even designing their own clothes could be left to men only at the risk of repetitive results. When allowed to dress themselves, they seldom could get beyond an envy of wombs and female genitals which restricted them to an endless succession of female sexual symbols. Thus, the open button-to-neck "V" of men's jackets was a well-known recapitulation of the "V" of female genitalia; the knot in men's ties replicated the clitoris, while the long ends of the tie were clearly meant to represent the labia. As for men's bow ties, they were the clitoris erecta in all its glory. All these were, to use Phyllis Freud's technical term, "representations." (p. 34)

Freud believed that phallic stage fixation can lead to a variety of conflicts, including issues related to sex role identity. For instance, the boy who is overly attended to by his mother and whose father is relatively uninvolved may exhibit traditional feminine characteristics or may become "macho" as he attempts to compensate for his lack of identification with his father. Or consider "daddy's little girl," whose mother is seen as subservient. This girl may become particularly self-centered and narcissistic, as she expects to be treated particularly well by all men in her life.

- **stage 4—latency stage:** Strictly speaking not a psychosexual stage, the latency stage occurs between the ages of five or six years and puberty, when there is a repression of the libido. During this holding pattern, the child focuses on peer relationships and other age-appropriate activities, such as athletics and school. However, the repression of one's sexuality soon ends with movement into the genital stage.
- **stage 5—genital stage:** Occurring around the onset of puberty, in this stage there is a resurgence of one's sexuality. Also in this stage, the resulting patterns of behavior from passage through the earlier stages become expressed. Fixation at these earlier stages will yield neurotic and psychotic behaviors, according to Freud.

Although Freud has been criticized for what some have described as his extreme focus on the erogenous zones and their effect on personality development, many today view Freud's theory from a broader perspective (e.g., Kupfersmid, 2012). These individuals tend to focus more on a global view of the growing individual at early stages of development and how parenting skills affect the developing child (see Box 2.8).

BOX 2.8 A Modern-Day Look at the Psychosexual Stages

Freud has been justifiably criticized for his extreme focus on the erogenous zones of the developing child as well as his assumptions that a girl's psychosexual development resulted in a whole gender that is inferior (Holowchak, 2012; Steinem, 1994). However, many have argued that a wider view of Freud's ideas on parenting had much to offer. In fact, Westen (1998, p. 334) noted that

relative to personality formation, "stable personality patterns begin to form in childhood, and childhood experiences play an important role in personality development, particularly in shaping the ways people form later social relationships," thus supporting Freud's basic assumptions.

For instance, the child who is under two years of age is mostly concerned with sustenance, being nurtured, early motor development, and beginning language development. Almost all would agree that young children are dealing with the beginning development of trust and feeling safe in the world. Imagine a parent who rarely holds their infant, lets the child go hungry, or slaps their baby when the baby cries out from hunger or not being held. This child will clearly form different attachments early in life and will undoubtedly develop a very different "character," or personality style, than the child who is lovingly held and fed when hungry.

Or think about the child in the anal stage who is just learning how to use the "potty" and gain independence. The parent who yells at this child's unsuccessful attempts to go to the bathroom or ridicules this child's early attempts at exploring the world is clearly raising a different child than the parent who is accepting of this child's early but unsuccessful attempts at toilet training or the parent who praises a child's attempts at exploration.

Finally, consider parents who create shame and guilt by chiding a child who is exploring their body versus parents who teach the child that one's body should be honored and special. And even more globally at this stage, think about the kind of moral imperatives children at this age (three to six) are hearing from their parents and the manner in which they are hearing them (e.g., for a child's misbehaving: "You're going to hell" versus "Let's see if we can find a different way of doing that.").

Transference and Countertransference

Early on in Freud's work, he realized that clients were projecting feelings, thoughts, and attitudes onto the therapist as if the therapist were someone else. This *false connection*, as Freud referred to it, suggested that clients were not really relating to the therapist but to a past image of an important person in the client's life (Freud & Breuer, 1895/1974). Calling this *transference*, Freud realized that these *projections* could play an important role in uncovering the impact that significant relationships had on the client's life. If the client were indeed responding to the therapist as if they were someone else, helping the client to understand this process could open the door to important client insights. For instance, on a very basic level, if they are seeing their therapist as aloof and emotionless, it could be that this was their experience of their father (or mother), and they are transferring (i.e., projecting) these feelings onto their therapist, ultimately believing that this is indeed how their therapist is. Helping them understand this could free them from creating a "false connection" with the therapist or, indeed, with other significant people in their life. Thus, one of the goals of psychoanalysis is to assist the client in seeing this *transference relationship* that has been created, so the client can relate more honestly with the analyst and with others:

> The patients, too, gradually learnt to realize that in these transferences on to the figure of the physician it was a question of a compulsion and an illusion which melted away with the conclusion of the analysis. (Freud & Breuer, 1895/1974, p. 392)

A corollary to transference is *countertransference*, or the unconscious transferring of thoughts, feelings, and attitudes onto the client by the therapist. If the therapist sees the client as someone other than who they are, the therapist is working with an imaginary client—one who was manufactured by the therapist's own projections. One of the first times Freud talked about countertransference

and potential problems that could occur was in response to a letter from Carl Jung about Jung's sexual relationship with his patient Sabina Spielrein: Freud urged Jung to put an end to the relationship (Aguayo, 2012).

Countertransference can be devastating to the therapeutic relationship, and since the process is unconscious, the only way to lessen countertransference is for the therapist to have undergone their own therapy to minimize unresolved issues that may cause such projections and for the therapist to participate in supervision, so an objective third person can assess the therapeutic relationship. Now, what if the supervisor has countertransference to the therapist, or to the client, and the therapist has countertransference to the client? What a mess! (See Figure 2.4.)

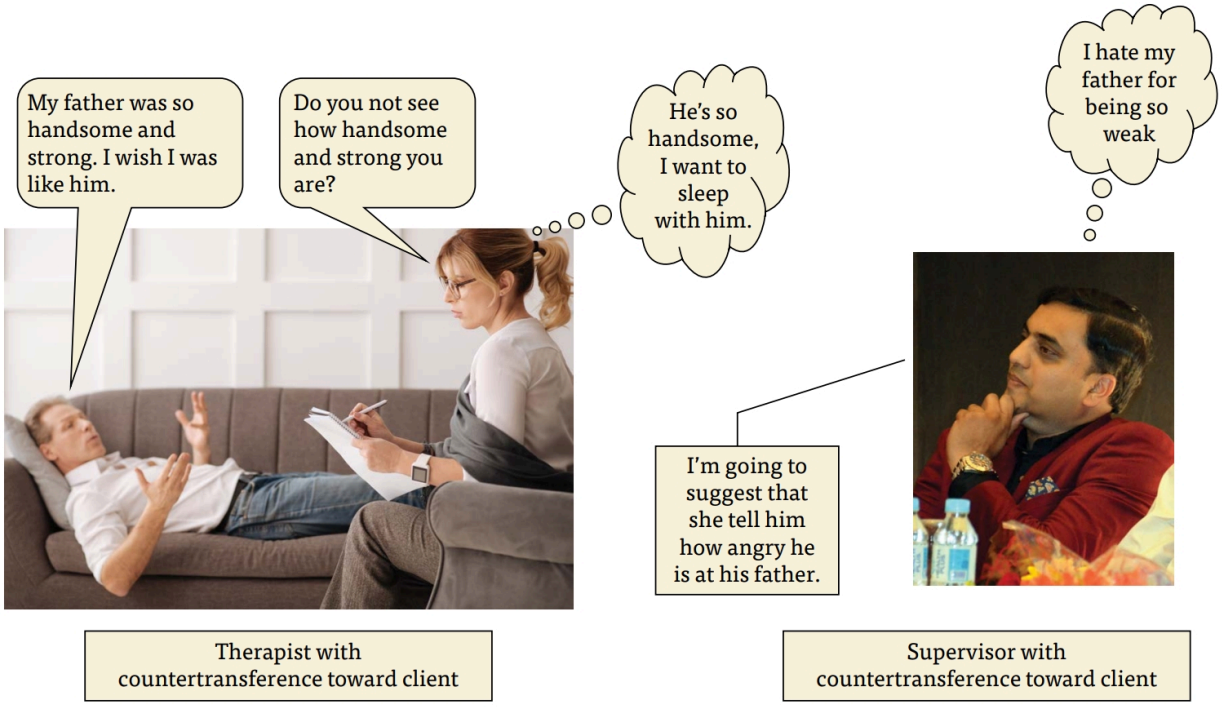

FIGURE 2.4 Countertransference Gone Awry

Therapeutic Techniques

Traditional psychoanalysts believe that all children are faced with the inherent struggles that each of the psychosexual stages pose, although effective parenting can ease these struggles and is critical to healthy functioning. The result of passage through these stages is the development of defense mechanisms, and the purpose of classical psychoanalysis is to help the client understand how they have come to use defenses in an attempt to mediate psychic energy. Defenses are healthy if they can effectively route psychic energy toward acceptable behaviors. However, they become dysfunctional when they lead to behaviors that cause problems, as manifested in neuroses or psychoses. Thus, clients are encouraged to uncover the true meaning of their behaviors, which reflect how psychic energy gets diverted through the psychosexual stages, and the therapist can help interpret how early childrearing impacted the development of such behaviors. This can clearly be a labor-intensive process and can take years. A number of techniques, identified earlier, facilitate deeper understanding by clients, including creating a trusting atmosphere, free association,

interpretation of resistance, dream analysis, interpretation of parapraxes, and interpretation of the transference relationship (Ursano et al., 2004).

Creating a Trusting Atmosphere

If clients are to feel free enough to share feelings, thoughts, and behaviors that can be deeply embarrassing and shameful, the analyst must create an environment safe enough to encourage such revelations. In classical analysis, the analyst would use analytic neutrality, which was accomplished by having the client lay on a couch, while the analyst sits in a chair off to the side and listens carefully. Encouraging the client to share their deepest thoughts, the analyst would respond with a nonjudgmental stance to any client revelations. Today, most analysts have given up the aloofness of the couch and have a more engaging style, in which periodic self-disclosure might even be seen as appropriate to build the relationship and explore the inner thoughts of their clients. In either case, many of the basic precepts of classical psychoanalysis are adhered to. For instance, it is core to all analytical approaches to examine the transference relationship, wherein the client projects early patterns from significant relationships onto the analyst and begins to view the analyst as embodying qualities of these significant people from the client's past. At appropriate times, the therapist can then interpret these projections for the client and show how they are related to early child-rearing issues (see Interpretation of the Transference Relationship).

Free Association

Free association is when the analyst invites the client to say whatever comes to mind, without filtering, and results in the expression of true thoughts, feelings, wishes, and desires, even if the thoughts seem irrelevant, unimportant, or too distressing to talk about publicly. Free association assumes that the psyche tries its best to protect itself from exposing repressed material in an effort to maintain the current manner of functioning and one's ego defenses—even if that manner of functioning is dysfunctional.

Interpretation of Resistance

Resistance is any client behavior that impedes or prevents the analyst from gaining access to the client's unconscious and is often a signal that the client is close to dealing with an important unconscious issue. Resistance can be particularly destructive when it impedes free association but can occur throughout the relationship. Some examples of client resistance may include showing up late or missing appointments, getting upset and angry at an analyst, or retreating or regressing in therapy. Interpretation of resistance helps clients examine why they are being resistant, so they might deal directly with the threatening issue inherent in the resistance.

Dream Analysis

> The interpretation of dreams is the royal road to a knowledge of the unconscious activities of the mind. (Freud, 1899/1976a, p. 769)

Freud believed that dreams are a projection of our unconscious and represent symbolic images of our desires and wishes. These images, said Freud, have manifest and latent meanings. *Manifest meanings* are the obvious, more conscious meanings of the dreams, while *latent meanings* are underlying, preconscious meanings—meanings that are repressed in our dreams but can be discovered through analysis. Although clients often feel more comfortable sharing the manifest

meaning of a dream, within a trusting environment, they will eventually feel comfortable delving into the latent meaning.

Interpretation of Parapraxes

> He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his fingertips; betrayal oozes out of him at every pore. (Freud, 1905/1953, pp. 77–78)

So a client walks into his analyst's office chuckling to himself, and says: "How many therapists does it take to change a light bulb?" Going along with this "joke," the therapist says, "How many? Tell me?" The client says, "Just one, but the light bulb has to really want to change." The analyst then looks at the client and says, "Are you telling me that maybe you don't really want to change, and I'm going to have to work really hard to help you change?" The client, who just thought he was telling a joke, suddenly realizes that maybe there was something else behind this "joke."

Jokes are a type of *parapraxes*, or errors of speech, slips of tongue, "misspeaks," or subtle behaviors that reveal unconscious meanings that are symbolic of repressed wishes and desires (Freud, 1905/1976c). Of all parapraxes, perhaps the best known is the *slip of the tongue* or *Freudian slip*. Interpretation of such slips in a timely fashion could help the client understand the hidden meanings behind such a slip.

In addition to jokes and Freudian slips, Freud believed that such things as satire, nonverbal behaviors, atypical behaviors, misspelled words, forgetting words, bungling actions, and so forth could be symbolic of hidden desires and conflicts (Freud, 1901/1989; see Box 2.9). On the other hand, when a student asked Freud, who smoked cigars incessantly, what the symbolic meaning of a cigar might be, he reportedly stated, "Sometimes a cigar is just a cigar."

BOX 2.9 Our Nonverbals Say More Than We Think

Dr. Paul Ekman spent years researching the nonverbal behaviors of humans and found that facial expressions and body movements are universal and consistent across cultures (Ekman, 2016). Thus, if you can "read" a person's nonverbals, you can sometimes tell what they are actually saying or whether they are lying or telling the truth. Ekman was particularly good at this, and a TV detective series, *Lie to Me*, was created based on his ideas.

From a psychoanalytic perspective, this makes perfect sense. No matter who we are with, we cannot really lie to them. The person we are communicating with is constantly picking up on our nonverbals, our jokes, our Freudian slips, and more, and that person can tell something about the truth, or untruth, of what the other person is saying. Some people are better than others at picking up truths (or lies), but the psychoanalyst would assert that on a conscious or unconscious level, we all can tell when another person is lying to us. So next time you think you are hiding something from someone, think again!

Interpretation of the Transference Relationship

As noted earlier, a cornerstone of the relationship with the analyst is the development of the transference relationship in which the client projects or "transfers" onto the analyst thoughts, feelings, fantasies, and patterns of behavior that were indicative of early relationships, often parents. As an example, the client who calls her therapist "stingy" might be projecting repressed childhood

feelings of being unloved by her parents (stingy with love) that resulted in the adult client feeling a sense of emptiness. This need for love is falsely experienced with the therapist and with many people in the client's life as an inability of others to show love—not as an unresolved longing for love that originated in the client's childhood and gets repeated in relationships throughout the client's life. Thus, timely therapeutic revelations through *interpretation of the transference relationship* can help the client understand their projections. Such interpretations not only resolve issues within the therapeutic transference relationship but also help develop increasingly real relationships with other important people in the client's life. In a sense, Freud and others were suggesting that our relationships are based on falsehoods and are an illusion. Perhaps, it is no wonder that divorce rates are as high as they are.

The Counseling Process

Traditional psychoanalysis is a long-term, in-depth process in which the client may meet with a therapist three or more times a week for five or more years. To build the transference relationship, the analyst remains relatively quiet vis-à-vis the client. Empathy and listening skills are crucial at the beginning of therapy to help build the alliance, develop *analytic neutrality*, and help anchor the client in the relationship. Throughout the relationship, client resistance is pointed out and discussed if the client seems amenable to hearing the interpretation (e.g., coming late, not paying, missing appointments, or seeing the analyst as incompetent). As therapy continues, interpretation and analysis become key techniques. Over time, and as issues are resolved, the client will begin to see the therapist in a more objective and realistic manner. Later in the therapeutic process, as anonymity becomes less important, the therapist may feel free to reveal small aspects of themself. Ultimately, the relationship ends when the client has gained increased knowledge of self and awareness of how underlying dynamics are expressed through their patterns and symptoms and when the client has made some changes based on these insights. It should be noted, however, that since so much of our behavior is mitigated by our unconscious desires and needs, therapy can only unravel a portion of why we do what we do. However, even small insights into our psyche and the forces that shape our behaviors can lead to changes in how we view ourselves and interact with others.

Today, many psychoanalysts see clients for free or at a reduced cost, and the traditional method of analysis is often adapted based on new knowledge and the current needs of society. So it is not unusual to see many analysts practicing a modified psychoanalytical approach in which a client is seen once a week. Although not a short-term approach, such a modified approach can have wider appeal. What might the world look like if we all underwent some version of modern-day psychoanalysis? It is likely we would have much greater understanding of our motivations and increasingly make intentional choices that would result in less harm to self and others and more peace and harmony in the world.

Social, Cultural, and Spiritual Issues

For years, psychoanalysis neglected the social, cultural, and spiritual contexts of individuals, and research on, and the practice of, psychoanalysis has traditionally excluded a focus on race and ethnicity (Tummala-Narra, 2015). This resulted in individuals from marginalized racial or ethnic and socioeconomic statuses not having access to treatment and a culturally encapsulated practice that was based on the values and beliefs of well-to-do, White, European men (Teusch, 2021; Tummala-Narra, 2015). In addition, Freud developed psychoanalysis during a time of *modernism*, or the belief in objective and universal truths about human behavior by which the scientific method could be used to discover so-called truths about the psyche (Hansen, 2010).

The modernist movement in Europe and the United States contributed to a medicalization of psychoanalytic theory and practice, situating the locus of pathology to be within the client, not the result of external factors.

Although Freud lived in a world of modernism and the White upper class cultural values of the time, his experience with anti-Semitism and poverty as a child also informed his worldview (Teusch, 2021). In some ways, he lived in two contradictory worlds. For instance, while he linked experiences between Jewishness and Blackness, such as anti-Semitism and anti-Black racism, he also showed identification with Whiteness and rejection of his Jewish identity (Gaztambide, 2019). Freud was not ignorant of cultural differences, and as he and other psychoanalysts evolved, they began to extend the practice of psychoanalysis to individuals marginalized along social class lines.

Freud's evolution toward cultural inclusion was first noticed when he called for economic justice during a keynote address at the Budapest Psychoanalytic Congress. He envisioned a future in which "conscience of society will awake and remind it that the poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery, and that the neuroses threaten public health no less than tuberculosis" (Freud, 1919, p. 155). In the address, he advocated for treatment to be mindful of clients' economic as well as psychological needs. In fact, between 1918 and 1938 free or sliding scale clinics throughout Europe were established, which made psychoanalysis accessible to those unable to pay for treatment (Teusch, 2021).

Others also advocated for marginalized groups. For example, *Sandor Ferenczi* (1897–1946), a socialist and first-generation psychoanalyst, advocated for humane medical treatment of LGBTQ+ individuals. His work with these clients focused on empathy and the importance of client validation of experience. Another example of social justice and antiracist work was when Black novelists *Ralph Ellison* (1913–1994) and *Richard Wright* (1908–1960) partnered, in 1946, with German American psychoanalyst *Frederic Wertham* (1895–1981) to open the Lefargue Mental Hygiene Clinic in Harlem and offered free and sliding scale services to Black people (Teusch, 2021). Furthermore, *Arthur Ramos*, a Brazilian psychoanalyst, identified cultural trauma and marginalization as sources of adult misbehavior and violence: "Using Freud, Ramos argued that perceived 'criminality,' 'primitivity,' and 'mental atavism' projected onto indigenous and Black populations were instead the product of trauma, poverty, racial inequality, and marginality" (Gaztambide, 2019, p. 129).

With the transition into *postmodernism*, social context and socially constructed meanings became increasingly central when conceptualizing clients' intrapsychic and interpersonal experiences. Thus, tenets of postmodernism have been infused within the practice of contemporary psychoanalysis, embracing notions of multiple subjective truths that are socially constructed, while focusing less on early Freudian concepts, such as psychosexual development. Hansen (2010) added:

> Psychoanalysis ... has sometimes been wholly dismissed in contemporary mental health discourse because of the seemingly bizarre types of diverse, intrapsychic experiences that Freud (1905/1958) initially posited, such as sexual desires toward one's parent pitted against castration anxiety. In other words, the content of early Freudian ideas has been emphasized at the cost of ignoring the overall image of intraindividual diversity that psychoanalysis proffers. (p. 19)

Neo-Freudians, such as *Harry Stack Sullivan* (1892–1949), *Karen Horney* (1885–1952), and *Erich Fromm* (1900–1980), developed strands of *interpersonal psychoanalysis*, which de-emphasized the importance of innate drives and asserted that an individual's interpersonal relationships, within the context of social and cultural experiences, impacts their psyche. Furthermore, they and others viewed interpersonal responses as a mechanism of reducing anxiety and maintain one's self-concept (Vazquez, 2014).

Several Freudian concepts have evolved as a result of postmodernism. For example, emotional insight can be conceptualized as the co-construction of the therapeutic relationship, whereas both client and counselor are changed (Tummala-Narra, 2013). Counselors and psychotherapists can help foster emotional insight and identify unconscious and conscious thoughts to promote client change. As such, attention to therapeutic interactions and their impact on individual development are to be a part of psychoanalysis "wherein the counselor and client are both continually making psychological contributions to the interpersonal field" (Hansen, 2010, p. 21).

Second, social position is situated within the psyche and reproduced in transference and countertransference and, thus, in part, culturally based (Tummala-Narra, 2015): Therefore, the internal conflict that clients (and counselors and psychotherapists) may encounter signal intra-individual diversity, which can be addressed by cocreation of new meaning in the therapeutic relationship during psychoanalysis. Thus, psychoanalysis calls on the counselor and the client to reflect upon their racial identity and engage in effective cross-racial therapeutic relationships (Tummala-Narra, 2013).

Third, psychoanalysis helps clients understand power, privilege, and oppression, and the purpose that the superego serves in minimizing violent tendencies (Teusch, 2021). Specifically, Freud's suggests that the superego can serve a protective factor among the masses to prevent violence:

> Culture and society attempt to tame the rage and hatred of individuals and groups by setting up the superego with them. This internalized sense of guilt, whose aim it is to prevent the repetition of violence, serves a pro-social function in that it helps with the recognition that "the other" is also a human being, like the self- deserving of love and should not be killed. (Teusch, 2021, p. 546)

Psychoanalysis also has implications for addressing spiritual issues within counseling and psychotherapy (Tummala-Narra, 2009). Although an atheist, Freud had a complex view of religion in that he believed that early tribes needed to "find" an external force to control primal urges and prevent the tribe from killing itself off. Thus, he said, it manufactured (projected) "gods" to pray to and gave these external authorities the power to control internal drives. Freud also believed that as the child comes to grips with the fact that they are not more powerful than the father, the father becomes a revered and internalized all-powerful figure. This *imago*, or idealized image of the loved father, then becomes projected onto the world in the form of God (e.g., Christ, Allah, Buddha, and Yahweh). Freud respected those who reflected on the complexity of religion but also believed that most people were caught up in their projections and could not see that they lived in a fantasy world:

> It is … humiliating to discover how large a number of people living to-day, who cannot but see that this religion is not tenable, nevertheless try to defend it piece by piece in a series of pitiful rearguard actions. (Freud, 1930/2005, pp. 49–50)

Freud suggested that religion was used to avoid one's ultimate fears concerning living and dying. However, others have taken a kinder view of psychoanalysis and religion. For instance, MacIsaac (1974) suggests that original sin is an important concept with which we all must come to grips and is very similar to Freud's concept of unconscious instinctual drives—the id. Today, many analysts still agree that some aspect of what we call "God" is a projection from one's unconscious; however, they tend to not eliminate the concept of God in its totality, as Freud did (Black, 2006). Religion, spirituality, and the acceptance of God are now seen as choices that each client and analyst make on their own and are not necessarily seen as avoidance of deeper life-and-death issues. For those of racial or ethnic marginalized statuses and women, religion and spirituality can represent an institution of either community survival or symbolic of patriarchal structure, respectively. Counselors

and psychotherapists are encouraged to explore individual meanings of religion and spirituality as clients develop deeper meaning of self.

Finally, in addition to developing a critical consciousness through therapeutic dialogue, the literature offers additional strategies for attending to social and cultural issues. Tummala-Narra (2015, p. 282) identified the following approaches to a culturally competent practice of psychoanalysis:

- Expand self-examination to include the exploration of effects of historical trauma and neglect of sociocultural issues in psychoanalysis on present and future psychoanalytic theory and practice;
- Recognize clients' and therapists' indigenous cultural narrative and the conscious and unconscious meanings and motivations accompanying these narratives;
- Recognize the role of context in the use of language and the expression of affect in psychotherapy;
- Attend to how client's and therapist's experiences and social oppression and stereotypes of the other influence the therapist, the client, and therapeutic process, and outcome; and
- Recognize that culture itself is dynamic and that individuals negotiate complex, intersecting cultural identifications in both creative, adaptive ways, and self-damaging ways, as evidenced in the use of defense.

Efficacy of Psychoanalysis

Although psychoanalysis is practiced today around the world, its likely best outcomes are with individuals who are comfortable with traditional Western values. Psychoanalysis can be a grueling experience and is probably more amenable for those who know what they are getting into, are committed to the process, and are willing to immerse themselves in a long-term therapy.

Psychoanalysis has seen a steady decline since its heyday in the 1940s and 1950s (Cortina, 2010), partly a result of the lack of systematic research conducted and sophisticated research methods needed to show its effectiveness at that time (Cortina, 2010). In addition, psychoanalytic theory has evolved over the course of 100 years and are rich and complex, and some of the ideas are not compatible with each other (Stepansky, 2009). Although evidence of psychoanalysis is insufficient at best, given its changes over the century, available efficacy research shows promise for its tenets and outcomes.

Available research does indicate that psychoanalysis sets in motion psychological processes that lead to ongoing change, even after therapy has ended (Abbass et al., 2006; de Maat et al., 2009; Knekt et al., 2011; Messer & Abbass, 2010; Shedler, 2010; Trowell & Tsiantis, 2018). For complex mental health disorders (e.g., personality disorders or chronic depression), psychoanalysis can be particularly effective (Leichsenring et al., 2016; Leuzinger-Bohleber et al., 2018; Luyten & Blatt, 2012; Woll & Schonbrodt, 2019). The efficacy of short-term psychoanalysis in improving symptoms and interpersonal functioning has also been demonstrated through meta-analyses involving randomized controlled trials (Dreissen et al., 2016; Leichsenring, 2005; Leichsenring & Leibing, 2007). Psychoanalysis has been demonstrated to be effective in both individual and group settings (Amodeo et al., 2017) and with children, adolescents, and adults (Deakin & Nunes, 2009; Midgely & Kennedy, 2011; Shedler, 2010).

Studies examining specific mental health disorders show psychoanalysis to be effective in reducing symptomology, specifically in cases where client symptoms are severe. For instance, researchers have found significant positive changes in treatment of moderate and severe depression for adults (Driessen et al., 2010, 2016; Johansson et al., 2012; Leuzinger-Bohleber et al., 2018; Luyten & Blatt, 2012) and children and adolescents (Houseby et al., 2021; Trowell & Tsiantis, 2018; Weitkamp et al., 2014), suicidality and self-harm (Briggs et al., 2019), anxiety disorders (Egger et al., 2015; Göttken et al., 2014; Knekt et al., 2011), personality disorders (Bateman & Fonagy, 2001; Leichsenring et al., 2016; Streeck-Fischer et al., 2020), attention-deficit/hyperactivity disorder

(Laezer, 2015), somatic disorders (Abbas et al., 2009), and intellectual disabilities (Beail, 2017; Shepherd & Beail, 2017). In addition, issues related to academic identity (Amodeo et al., 2017) and general interpersonal problems in school settings (Deakin & Nunes, 2009) have been effectively treated through short-term psychoanalysis.

Research specific to some key psychoanalytic concepts has been conducted in more recent decades:

- The unconscious, where information is processed out of awareness, has been shown to be parsed in different memory systems at implicit levels rather than as repressed materials (Cortina, 2010).
- Unconscious material has powerful effects on motivation (Aarts et al., 2008).
- Recent advances in neuroimaging indicate that aspects of the brain respond to emotion without conscious awareness and that specific areas of the brain are associated with unwanted memories, thus offering some evidence for an unconscious (Cramer, 2006).
- Neuroimaging has signaled the presence of the defense mechanisms of denial, projection, and identification, which increase under stress (Cramer, 2006).
- Building a therapeutic alliance, so key to the psychoanalytic process, has been shown to be one of the most important qualities in successful outcomes of any therapy (Tummala-Narra, 2013).
- There is compelling evidence that the past influences personality development but does not determination it and that early developmental tasks are related to psychological processes later in life (Cassidy & Shafer, 2008; Shedler, 2010).

As you might imagine, researching the effectiveness of psychoanalysis is not easy. How, for instance, can one measure changes in id and superego conflicts, early problems with attachment with parents, and other unconscious struggles. Also, since psychoanalysis tends to be long-term, studies would need to consist of lengthy, longitudinal research that follows individuals for months, if not years. Setting up such studies, getting permissions to follow clients for that period, and problems with attrition can make this particularly difficult.

What is needed is an ongoing effort to define and operationalize basic psychoanalytic concepts that have withstood the test of time. Although there is more research than in the past on psychodynamic and psychoanalytic therapies, there have been limited attempts to operationalize and test basic psychodynamic concepts and available randomized control trials are few and of questionable quality (Shedler, 2010). Indeed, a greater number of qualitative and qualitative studies are needed to evaluate the complexities of psychoanalysis.

The Millers

The following shows Jake going through psychoanalysis. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Jake's Experience With a Psychoanalytic Therapist

Standing in the doorway of the office, Jake nodded as Dr. Eckman, a short, white-haired man in his early seventies, motioned him toward a squat, earth-colored couch perched behind a deeply stained oak coffee table. A corner desk to the left was piled with folders, old books, and an array of mismatched coffee mugs. As he took in the atmosphere of the office, Jake glanced around the room noticing the surreal quality of the moment, unsure exactly how things had gotten bad enough that he needed therapy. Dr. Eckman invited Jake to sit. "I thought I was supposed to lie down on the couch," Jake offered, only half-teasing. "You can if you like, but it doesn't usually work that way

anymore," Dr. Eckman offered a knowing smile and continued, "Based on our brief phone conversation, it sounds like you are getting discouraged and feeling like you are out of options. Can you tell me a little more about what is going on?"

"I was just wondering that myself." Jake smiled slightly, feeling more comfortable already. "I guess I've always been a bit of a worrier, but things are much worse now. As I mentioned on the phone, I recently had a panic attack. I'm almost more worried about having another one than I am about something happening to the kids—well, almost. I'm completely powerless when the panicked feeling starts," Jake began.

"Tell me about the last panic attack you had," Dr. Eckman encouraged.

"Luke and Celia, they are my kids, were playing in the car. I've told them not to mess around in the car, but of course they were not listening, and that day they were playing in there together. Anyway, Luke knocked the car out of gear and while they were sitting inside, it rolled into the street in front of our house! That was a big trigger for me. Suddenly, memories of when my sister and I were their age flashed in front of my mind, back to a time when Justine and I were messing around in my dad's car and my sister was nearly killed," Jake shook his head as if to erase the thought from his mind. "I think seeing those kids in the street like that just flipped me out." Dr. Eckman nodded as Jake continued, "I know I have been unreasonable at home, but I can't seem to control my fear that something horrible might happen to Angela or the kids. A part of me wishes that Angela and the kids would just stay home, never leave ... I asked Angela to homeschool Celia, and we had a big fight about it. Part of me knows how unrealistic and unfair that sounds, but the other part really wants it. It just seems like all this anxiety is getting in the way of our relationship."

After the first session with Jake, Dr. Eckman began to form a few hypotheses; his first concern was for the relationship that was developing between him and Jake. He hoped Jake would be able to share comfortably. Dr. Eckman noted that Jake had been able to make connections between his experience with his sister and his fears about his own wife and children. However, Dr. Eckman continued to be curious about how Jake's childhood development shaped the configuration of his personality structure, the id, ego, and superego as well as neurotic patterns of thinking, acting, and feeling. Of particular interest is the complex interplay between the urges of the id and demands made by the superego and how these manifest in anxiety.

At the opening of the second session, Dr. Eckman noted, "Jake, you seem to be favoring your right leg. What happened?"

"Oh, that," Jake replied, reddening a bit. "That happened in the accident I was in with my sister." Jake swallowed and continued, "When the semi hit Dad's car, Justine went through the windshield. The front end of the car was smashed in, and there was some permanent damage to my hip. I broke a couple of ribs, and I had a bad concussion."

"You hadn't mentioned that before. It sounds like you were hurt pretty bad," Dr. Eckman prompted.

"Yeah, I guess, so. I don't ever really talk about what happened to me. It was Justine that really had it bad, you know. She has a brain injury and—well, it was just bad, that's all."

"You had quite a long recovery; you are lucky to be alive," Dr. Eckman probed further. "How did you two end up in the car in the first place?"

"Wow, I haven't thought that far back in a long time." Jake's expression grew serious. "Well, you know, Justine was about the bravest girl I ever knew. There was never a challenge that she wasn't ready to tackle. She was incredible. And she was really, really smart, too." Jake's glance drifted to a cluttered corner of the room as he began to share his memories, almost as if talking to himself. "Justine really wanted to play a trick on Dad and take the car and hide it in the woods. As usual, I was scared and tried to talk her out of it, but she was sure it would be really funny. So finally, I caved. I remember she had her bare feet curled up under her in the front seat—the seatbelt hanging loose at her side. I told her to buckle up, but she just laughed at me." After a moment, Jake made eye contact with Dr. Eckman, "Dr. Eckman, you look so sad."

"Jake, I'm just reflecting the sadness I feel from you." Jake swallowed and felt the tears rising in his throat.

As their work continued, Dr. Eckman was able to identify a number of defense mechanisms he believed had served an important role in Jake's life by staving off anxious feelings emerging from his unconscious. Through the use of free association, dream analysis, exploration of memories and fantasies, and interpretation, Dr. Eckman exposed four primary defense mechanisms: repression, idealization, reaction formation, and denial. Sitting down with Jake's chart, Dr. Eckman began to make sense of Jake's defensive responding. Dr. Eckman summarized his understanding of Jake's defenses this way:

- **repression:** In his sessions, Jake is able to remember his sister's insistence that the two of them take their father's car, including a vivid memory of her sitting next to him moments before the accident. However, as he has been able to recall more of the incident, he has begun to remember that Justine had to bully him into doing the prank in the first place. Jake has gained access to the (id-based) anger and resentment he felt toward Justine directly after the accident for "making him" do the prank and has realized that he repressed this anger because it is in conflict with how he thought he "should" feel (superego: he should feel bad for his sister). Over the years, Jake's repression has not been entirely successful in containing the unacknowledged anger and resentment. It has seeped out in his anxiety and panic attacks, in his dreams, in periodic quips he aims at his sister, and in his sometimes obsessive–compulsive behavior toward making sure that his wife and children are "safe."
- **idealization:** Jake appears to have had a realistic relationship with his sister prior to the accident. However, since the accident, he has idealized her. He now only speaks highly of her and often refers to the bold and fearless behaviors that she had as a child. He can no longer see her as she was or as she is today. His idealization of her allows him to sidestep his full range of feelings, which include anger, guilt, sadness, and love.
- **reaction formation:** Jake unconsciously holds anger toward his sister for "making" him drive the car. He also feels guilt for being the driver. The guilt is significant, given the severity of Justine's injuries and his parents' values for "always doing the right thing"—values he has introjected. Jake seems to avoid these unacceptable feelings by nearly always being nice to his sister, although once in a while he quips at her (parapraxes!). His idealization of her makes it easier for him to maintain this mask of niceness.
- **denial:** Although Jake was nearly killed when the semi slammed into his father's car, he has been unable to talk about this aspect of the accident, or even discuss his own extensive injuries. Until now, they have been denied altogether. Coming so close to death himself, Jake is terrified of death. However, these thoughts, and their associated fears, are now slowly seeping into preconsciousness. His "edginess" toward his wife and his anger toward his "wild" and "impossible-to-control" son are indications that his denial is no longer working for him.

  It is Dr. Eckman's belief that all people with healthy egos use defense mechanisms at one time or another; however, he believes that psychopathology develops when defense mechanisms fail to contain anxiety or are used to avoid or distort reality, or when defensive attempts to contain anxiety become self-destructive. By Jake's own admission, his fears have become so exaggerated as to be out of sync with reality. As his defense mechanisms begin to falter, he has exhibited feelings and behaviors, like anger, edginess, and a need to control others, that have deleteriously affected his relationships with his family, particularly his wife and son.
- **Future Directions:** As Dr. Eckman considers the sessions to follow, he will work to illuminate Jake's defense mechanisms and bring Jake's unconscious thoughts and feelings into his conscious awareness. He believes that he must help Jake learn new ways of understanding and containing his anxiety, as the old ways are not working. He and Jake will continue to spend

a great deal of time exploring his past and making connections between these early experiences and the ways in which he responds to his family now. Although issues concerning the accident have been highlighted early in therapy, ultimately, Dr. Eckman hopes to uncover earlier relational issues with Jake's parents, as well as other significant people in Jake's life, who have served to form the structure of Jake's personality. Dr. Eckman hopes this process will put an end to Jake's demands that Angela stays near the house, his constant reprimanding of Luke, and his recent decision to ask Angela to homeschool Celia.

For You to Consider

1. Do you believe that talking through Jake's early experiences is important to understanding the anxiety he feels and the control he needs today? Why, or why not?
2. Dr. Eckman is concerned about dynamics that are outside of Jake's conscious awareness. Do you feel his interest in unconscious dynamics should be prioritized over Jake's conscious thoughts? Explain.
3. Did you notice Jake using any defense mechanisms other than the four that were highlighted?
4. What types of transferences might you expect to see unfolding between Jake and Dr. Eckman? How might these show up in therapy?
5. Are you aware of feelings that you might have if you were working with Jake that could manifest in countertransference? For instance, do you experience irritation with Jake, an urge to nurture Jake, feelings of blame, or perhaps a desire to rescue Jake? How might countertransference show up in your work with Jake?
6. Relative to the course of treatment, how much time do you think Jake will need to discuss his presenting problem versus the time he will take to examine his general personality style as it relates to early child-rearing issues? Explain.
7. How long do you think treatment will last?
8. Do you think that medication might be an effective means of controlling Jake's anxiety, while he works on the underlying causes?
9. What cross-cultural factors could affect the analyst's relationship with Jake?
10. From a psychoanalytic perspective, if Jake came to you saying he had decided that he wanted to become more religious to "rid himself of the sin that he has perpetrated on his sister Justine," what would you think? How might you respond?
11. Although psychoanalysis is considered a long-term therapy when compared to many other forms of treatment, do you believe Jake might experience short-term gains through this approach?
12. What do you think the prognosis is for Jake?

Summary

The chapter began by offering biographical information about Sigmund Freud and how his theory influenced the world. Some of the major points covered included a description of Freud's family; information about individuals who influenced Freud's early work, such as Charcot, Fliess, and Breuer; Freud's understanding of how hypnosis helped Anna O. understand herself; and how his early work

influenced the development of such concepts as neurosis, the unconscious, free association, defense mechanisms, transference and countertransference, resistance, and dream analysis.

The chapter next examined the psychoanalytic view of human nature, and we particularly looked at the roles that instincts, drives, and the unconscious play in the development of personality. Using the tip-of-the-iceberg analogy, we examined the relationships among the id, ego, superego, conscious, and unconscious. We also discussed the importance of defense mechanisms in managing the id, ego, and superego. We pointed out that, through psychoanalysis, we can gain a greater understanding of our behavior, but a large portion of our selves will remain hidden and unconscious. We noted that Freud believed that our understanding of the world was based on how our psychological processes, unconscious and conscious, create what is called our psychic reality. We stated that, sometimes, psychoanalysis is considered deterministic in that our personalities are believed to be framed at a very young age and are quite difficult to change.

As the chapter continued, we provided detail about a number of key psychoanalytic concepts. We learned about the preconscious, the conscious, and the unconscious, and we noted that the goal of psychoanalysis is to make more of the unconscious conscious. We discussed drives and instincts, including our life instinct (Eros) and our death instinct (Thanatos), which together comprise the psychic energy that form the libido. We outlined the structure of personality, including the id, which is fueled by the pleasure principle and for which impulses are called primary processes; the ego, which operates from the reality principle and is often called the secondary process; and the superego, which is the internalization of moral imperatives. We then discussed three types of anxiety—realistic, moral, and neurotic—and their relationships to the id, ego, and superego.

The chapter next described defense mechanisms that the individual creates to deal with our various kinds of anxieties. Then, looking at the psychosexual stages of development, we discussed in some detail the oral, anal, phallic, latency, and genital stages. We pointed out that the development of personality occurs through a dynamic interchange between the id, ego, and superego and the developmental issues that are faced throughout these stages. We stated that as the child grows, their psychic energy becomes focused on different erogenous zones as a function of these stages. We discussed what might happen if a child's libido becomes locked or fixated at a particular stage and highlighted Freud's ideas about the Oedipal and Electra complexes. We also discussed the importance of examining the transference relationship in analysis and avoiding countertransference when working with clients.

Moving on to major techniques of psychoanalytic therapy, we highlighted the importance of creating a trusting atmosphere, analytic neutrality, free association, interpretation of resistance, dream analysis, interpretation of parapraxes, and interpretation of the transference relationship. We also looked at how these different techniques are used throughout the helping relationship in an effort to assist the individual in examining their unconscious and in understanding how early parenting issues affect personality development.

Examining some social, cultural, and spiritual issues related to psychoanalysis, we noted how Freud's cultural upbringing almost assuredly affected his theory and that early psychoanalysis has traditionally excluded a focus on race and ethnicity. However, Freud was aware of cultural differences and their impact on counseling, and he, and a number of other early psychoanalysts, advocated for treatment to be mindful of clients' economic and psychological needs. As psychoanalysis evolved, we noted how some analysts moved from a modernist to postmodernist perspective on therapy and how multiple perspectives shape the counseling experience with respect to social, cultural, and spiritual issues.

The chapter concluded by examining the efficacy of psychoanalysis. Here we pointed out that psychoanalysis has its best outcomes with those more comfortable with traditional Western values; the therapeutic alliance, so key to psychoanalysis, has been shown to be important to successful outcomes; and several studies show psychoanalysis's effectiveness for reducing mental health disorder symptoms with various populations and therapy modalities. However, we also noted that strong, empirical studies are limited, and more research needs to be conducted.

Key Words and Terms

abreaction
anal expulsive
anal retentive
anal stage
analytic neutrality
asceticism
castration anxiety
catharsis
character
compensation
consciousness
countertransference
death instinct
defense mechanisms
denial
deterministic
displacement
dissociation
dream analysis
drives
ego
Electra complex
erogenous zones
eros
false connection
fixated
free association
Freudian slip
genital stage
humor
hysteria
id
idealization
identification
imago
instincts
intellectualization
interpersonal psychoanalysis
interpretation of the transference relationship
introjection
latency stage
latent meanings
libido
life instinct
manifest meanings
modernism
moral anxiety
nasal reflex neuroses
neurosis
neurotic anxiety
objective reality
Oedipus complex
oral stage
parapraxes
penis envy
phallic stage
pleasure principle
polymorphous perversion
postmodernism
preconscious
primary processes
primitive mind
projection
projections
psychic energy
psychic reality
psychosexual stages
psychosexual stages of development
rationalization
reaction formation
realistic anxiety
reality principle
regression
repression
resistance
secondary process
seduction theory
slip of the tongue
somatization
splitting
structure of personality
sublimation
superego
suppression
talk therapy
Thanatos
tip-of-the-iceberg
transference
transference relationship
unconscious
undoing

Key Names

Adler, Alfred
Bernays, Martha
Bernays, Minna
Breuer, Josef
Charcot, Jean-Martin
Ellison, Ralph
Ferenczi, Sandor
Fliess, Wilhem
Freud, Amalia
Freud, Anna
Freud, Sigmund
Fromm, Erich
Horney, Karen
Jung, Carl
O., Anna
Pappenheim, Bertha
Ramos, Arthur
Rank, Otto
Sullivan, Harry Stack
Wertham, Frederic
Wright, Richard

CREDITS

Fig. 2.1: Max Halberstadt, "Sigmund Freud," https://commons.wikimedia.org/wiki/File%3ASigmund_Freud_LIFE.jpg, 1921.
Fig. 2.2: A.A. Weltmer, "Hypnotic Suggestions."
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Analytical Therapy (Jungian Therapy)

3

Learning Goals

At the conclusion of this chapter, readers will:

- be familiar with the life of Carl Jung and the historical context in which he created his theory
- obtain an understanding of Jung's view of human nature
- have knowledge of the key concepts of analytical therapy, including psychological types, which encompasses attitudes and mental functions; the psyche, including the conscious, personal unconscious, and collective unconscious; archetypes, including the persona, shadow, anima/animus, and the self; complexes; individuation; symbols; and synchronicity
- identify the major techniques used in analytical therapy, including dialectical process, active imagination, the use of creative techniques, dream analysis, amplification, transference and countertransference, and interpretation
- detail the therapeutic process of analytical therapy, with special consideration toward clients' developmental readiness as it relates to understanding the personal and collective unconscious
- understand important social, cultural, and spiritual issues relative to analytical therapy, including critics and supporters of Jung's approach relative to women's issues, cross-cultural adaptability, and his symbolic notions on religion
- be familiar with available scholarship regarding the efficacy of analytical therapy

This second chapter on psychodynamic approaches presents the major tenets of analytical therapy. We begin the chapter by discussing Carl Jung, the founder of analytical therapy, and outline how his personal history, his fascination of the metaphysical world, and deep interest in empiricism had a large impact on his beliefs about human nature and therapeutic change. After outlining major theoretical constructs and how they influence the therapeutic process, we will identify a number of commonly used techniques. This will be followed by a discussion of important social, cultural, and spiritual considerations, as well as efficacy research regarding the practice of analytical therapy. We conclude the chapter by applying analytical principles to Angela, a member of the Miller family.

Carl Jung

> Carl Jung lit his farts on camping trips, danced with tribal people in Africa, built a stone tower with his own hands, socialized with his patients, and installed his mistress in his house (breaking his wife's heart). He was unafraid to delve psychologically into mysticism, the occult, alchemy—anywhere he thought he could find truths. ... Some think of him as the first manifestation of the therapist-as-rock-star because he had groupies and often seemed more like a guru than a therapist. But Jung originated the basic form of psychotherapy still practiced today in most fields: unlike Freud, he faced his patients, talking, consoling, and taking their ideas seriously as they sat across a table. "I realized," he wrote, "that one gets nowhere unless one talks to people about the things they know. (Simon, 2007, Section 8: Carl Jung, para. 1–2)

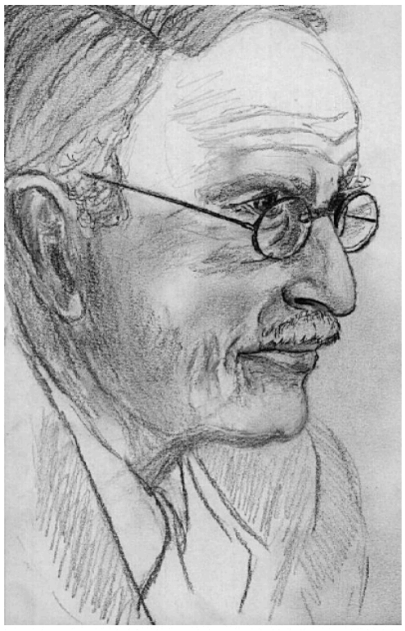


FIGURE 3.1 Carl Gustav Jung

Born on July 26, 1875, in a small Swiss village, *Carl Gustav Jung* was the only son of Paul and Emilie Jung, although they would also give birth to a daughter nine years later (Casement, 2015). The environment in which Jung grew up might be considered unusual by today's standards but was not uncommon in rural Switzerland at that time (Hayman, 2001; Jung & Jaffé, 1961). Surrounded by eight uncles and a father who were pastors, a mother who spoke with spirits, and a rural community that leaned heavily on a mixture of religion, magic, and spells, it is not surprising that the young Carl sometimes had trouble deciphering fantasy from reality.

Carl's parents, Paul and Emilie Jung, slept in separate bedrooms, and even to the very young Carl, it was clear that his parents were not in a "loving" relationship. Jung describes his mother in contrasting ways (Jung & Jaffé, 1961). On one hand, he saw her as sickly, often overcome by physical and emotional problems, obsessed with the paranormal, a critical parent, and a parent who was emotionally absent and even physically gone due to months spent in a mental hospital. On the other hand, he states that she was warm, fun, a good listener, strong, humorous, and pleasant. Although Jung felt close to his father, he described him as reliable but meek, irritable, depressed by his wife's emotional condition, and filled with faltering religious beliefs as a result of the ill-tempered atmosphere in the home. He believed that the household mood was partially responsible for his growing introversion and secretiveness, a knee-jerk negative reaction to the word "love," and even a severe case of eczema he had at the age of six.

Jung's home life was one in which he would encounter ominous-looking priests dressed in black, heard people weeping at the cemetery near his house, heard strange noises at night in his home, saw his mother trying to communicate with spirits, and had ongoing thoughts and daydreams about the nature of good and evil and Satan and Jesus (Jung & Jaffé, 1961; Lachman, 2010). Between the ages of six and 10, Jung showed an odd curiosity toward such things as corpses from a flood, setting fires, and watching the slaughtering of pigs. At the same time, he was drawn to intellectual pursuits, would often visit museums, was intrigued by the arts, and learned Latin at a very young age. The unusual and murky home atmosphere, along with a series of illnesses, such as croup, was at least partly responsible for periodic psychotic-like visions:

> One night I saw coming from her [mother's] door a faintly luminous, indefinite figure whose head detached itself from the neck and floated along in front of it. (Jung & Jaffé, 1961, p. 18)

Life at school was not much better than his home life. Having trouble relating to his peers, he increasingly alienated himself by daydreaming, playing with fire, and making towers out of blocks (Hayman, 2001; Lachman, 2010). Interestingly, it was Jung's depressive childhood that led him to one of his greatest discoveries. One day, while experiencing the negative home atmosphere, Jung decided to carve a manikin out of wood. This manikin became his secret doll to which he would write messages and from which he felt comforted (Bishop, 2014). Later in Jung's life, he came to believe that the manikin was shaped like many figures carved in ancient civilizations and that this figure, along with others, arose from what he called the *collective unconscious*, or the depository of ancient images all people hold in common. This term was to be a cornerstone of Jung's theory.

When Jung was 11, he was sent to boarding school, where he realized how little he had compared to his wealthy peers (Lachman, 2010; Sherry, 2010). The stress of attending a new school, the emotional burden he carried from his gloomy home life, and a possible sexual assault perpetrated on him at some point in adolescence, made it difficult for Jung to maintain any close friendships. Increasingly, he became solitary, often wandering into elaborate daydreams, fantasies, and deep contemplation about religion, God, and the meaning of life. One day while away at school, Jung was pushed by a boy and fell, landing on his head. This injury sent him home, and he soon began to develop fainting spells when asked to go to school or to do homework. This "illness" convinced his parents to keep him home from school—for six months! However, after overhearing a conversation between his father and a friend who suggested that the young Carl might have epilepsy, Jung decided it was time to work hard on ridding himself of his illness. Reflecting on his fainting spells, Jung later remarks, "That was when I learned what a neurosis is" (Jung & Jaffé, 1961, p. 32).

Back at boarding school, Jung increasingly came to believe he had two personalities: an unremarkable schoolboy, who was inferior in dress and status and managed the daily routine of life, and a strong, authoritarian, and noteworthy man of the 18th century, who would raise his voice periodically (Lachman, 2010). In some ways, Jung seemed to think he was channeling this 18th-century personality or that it was a reincarnated soul. This tendency to differentiate aspects of self would later become a part of his theory, which he identified as *archetypes*. Although struggling emotionally, Jung excelled in school, despite hating competition and purposefully underachieving to avoid being at the top of his class.

After boarding school, Jung attended the University of Basel and decided to pursue a career in medicine, although he was also fascinated by religion, philosophy, spirituality, séances, and psychic phenomena (Jaffé, 1971; Lachman, 2010, 2015). Jung relates several experiences to psychic phenomena, such as when he saw a wooden table spontaneously splitting in half and a knife exploding into several pieces. Jung's different interests, no doubt, were a combination of his fascination with science, his family's focus on religion, and his mother's interest in spirits. Thus, when he was finally asked to find a focus for his medical studies, he went into psychiatry:

> Here was the empirical field common to biological and spiritual facts, which I had everywhere sought and nowhere found. Here at last was the place where the collision of nature and spirit became a reality. (Jung & Jaffé, 1961, p. 109)

Interest in science, spirits, and spirituality were common at the time, as society moved from the more traditional world that had relied on the church providing answers to life's questions to the modernist interest in science holding the truth. With an interest in both science and the occult, Jung eventually wrote his dissertation on the psychology of the occult based on the experiences he had with a 15-year-old medium.

In 1900, Jung accepted a position at Burghölzli, a renowned psychiatric hospital in Zurich run by the well-known psychiatrist *Eugen Bleuler*, and in 1903, he married *Emma Rauschenbach*, a young woman from a well-to-do family with whom he would have four daughters and one son (Lachman,

2010, 2015). At Burghölzli, Jung saw his first patient, *Sabina Spielrein*, a Jewish intellectual from a wealthy family, who was diagnosed with hysteria:

> [P]atient laughs and cries in a strangely mixed, compulsive manner. Masses of tics, rotating head, sticks out her tongue, legs twitching. (Hoffler, 2001, p. 120)

Jung's analysis of Sabina relied heavily on the use of free association (Felixson & Marton, 2002; Hoffler, 2001); however, believing free association promoted the dark and pessimistic aspects of the individual and limited other possible explanations of symptoms, Jung stopped its use. Jung ended up having an affair with Sabina, and after correspondence and intervention from *Sigmund Freud*, the affair eventually ended (Bishop, 2014). Interestingly, this affair helped Freud coalesce his thoughts on countertransference and the importance of having boundaries with clients. Eventually, Sabina became one of the first child psychoanalysts and became well-known in her own right. Even though she married and had two daughters, she never really got over her feelings for Jung. In the early 1940s, she and her two daughters were shot and killed by the Nazis during their invasion of Russia.

At Burghölzli, most of Jung's patients were living with schizophrenia, and Jung was fascinated by the different aspects of their personalities (Jung, 1918/1969a). It was during this time that Jung developed one of the first word-association tests, in which he examined the responses of individuals to a list of stimulus words. Eventually, he came up with the word *complex* to describe unusual and delayed responses that individuals had to groups of words that seemed to point to a problematic or neurotic area in a person's life (Gabrinetti, 2015). Jung came to believe that individuals could have one or more of an indefinite number of *complexes* (e.g., mother complex, father complex, and inferiority complex). Each complex, said Jung, could cause the person to act in distinctive ways, almost as if they were separate personalities. Eventually, Jung stressed that revealing and integrating the different complexes into consciousness through a process called *individuation* was a critical aspect of therapy (Jung, 1969b).

The early part of the 20th century saw Jung begin to develop his own ideas about analysis as he collaborated by letter with Freud, who was in Vienna. Seen as a father figure by Jung, Freud talked of Jung as his crown prince and possible successor (Bishop, 2014; Lachman, 2010, 2015). Although Jung disagreed with many of Freud's ideas, he wanted to be the "good son" and did not actively refute Freud. In 1907, Jung went to Vienna and met Freud for the first time. Vienna was becoming increasingly anti-Semitic, and it was good to have a non-Jew supporting Freud's ideas, as most of his inner circle was Jewish. For Jung, Freud offered mentorship and support for an approach that was still widely criticized in Europe. In 1911, Jung became president of the International Psychoanalytic Association.

Jung's private practice expanded, and he soon decided to leave Burghölzli. As his writings and thoughts became increasingly different from Freud's, he founded the Society for Psychoanalytic Endeavors. As Jung developed his theory, he knew that the eventual publication of his book, *Psychology of the Unconscious* (1916), would accentuate their differences, and the two decided to part ways in 1913, prior to its publication. The split devastated them both, and it is not surprising that at this juncture, Jung resigned as president of the International Psychoanalytic Association.

At around the same time that Freud and Jung split, Jung began to have dreams and visions about world destruction, which he initially thought to be psychotic in nature (Jung, 2009). Believing at first that he was on the verge of an acute schizophrenic episode, he later came to view such visions as reflective of the state of the world and believed that he had a special ability to be able to access this deep material. Relative to Jung's state of mind, Storr (1973) notes, "The borderline between being regarded as an inspired prophet and being regarded as mentally ill is often a narrow one" (p. 16). Jung came to believe that those with schizophrenia had a unique gift of being able to release unconscious aspects of self that we all harbor in what he eventually

called the *collective unconscious*, but only some, like himself, could do this while maintaining a sense of reality.

At the time when Jung was struggling with his inner world, he befriended and eventually had an affair with *Toni Wolf*, a former patient who became his confidante and likely influenced his work (Casement, 2015; Lachman, 2010). This would not be Jung's only affair but probably the one that would most impact him and the development of his theory. In fact, Wolf is often seen as the person who kept Jung grounded during these trying years. Jung's wife, Emma, eventually found out about the affair and tried to make him end it. However, the affair lasted for years, and Jung would even have Toni over for dinner with his wife and would meet her on a regular basis at his summer house at Bollingen.

Bollingen was a getaway for Jung and symbolic of his continued interest in spirits and the unconscious, as while he was there he would often have recurring dreams about death, visions, "hauntings," and would hear strange sounds at the house (McLynn, 1996). Jung's eldest daughter, who was described by Jung as having psychic powers, even told his father that she sensed corpses on the grounds of Bollingen. Later, a skeleton of a French soldier was found on the property, and Jung arranged to have a "proper burial" for the soldier's remains. These experiences were fodder for the development of his theory, especially his notions of how aspects of self that are out of consciousness impact one's understanding of the world.

As Jung continued to refine his theory, he became fascinated by common aspects of people's dreams, myths, fables, religious writings, and cultural artifacts and symbols (Jung, 2009; Ribi, 2013). He also showed interest in *Gnosticism*, a pre- and early-Christian religious belief that examined the development of the psyche as it relates to the transcendent soul; *astrology*, the relative position of celestial bodies in understanding human nature; and *alchemy*, the conversion of basic metals into precious metals (e.g., gold or silver). He also became interested in the belief that there was a liquid mixture that could extend life indefinitely. Jung was fascinated by the psychology of the human psyche and how we come to make sense of such experiences. And he saw in these beliefs the human species' projection of a deep-seated need to change and complete themselves—to undergo a metamorphosis from one form of consciousness to a newer, expanded consciousness and *wholeness* or *whole Self*.

As Jung reached his mid-40s, he increasingly became interested in other cultures and traveled worldwide to better understand the collective experiences of people. His travels deepened his interest in Eastern philosophies and religions and his belief in an unconscious, common collective experience that all people inherit. A prolific writer and worldwide lecturer, many of his ideas would eventually become well known (see Box 3.1).

At the height of Jung's popularity, the Nazis took hold in Europe, and in Germany Jews lost their jobs and professional posts. The German chapter of the Society for Psychotherapy threw out their Jewish members, and Jung took on the presidency of the newly formed International Society to allow Jews to have membership in what would be considered the umbrella association (Ellenberger, 1970). However, at that time and continuing into today, Jung's response to Nazi Germany has been a bone of contention for some. For instance, some have argued that Jung held unconscious anger toward Freud and other Jewish psychoanalytic leaders and that the Nazis' suppression of psychoanalysis provided Jung the opportunity to have *analytical psychology* become the prominent form of analysis (Hayman, 2001; Rowland, 2018; Sherry, 2010). Others believed that Jung's lack of response to the Nazis was because he waited to see if some good would come out of the Nazi regime, as all archetypes contain "good and evil." On the other hand,

BOX 3.1 Want to Meet Carl Jung?

Want to hear a brief biography about Jung from the man himself and find other tidbits of information about him? Visit https://silver.odu.edu/psyadm/ to see a caricature of Jung talking about himself and his theory. Click on the psychodynamic door and go into Jung's office.

many Jewish analysts, including many of whom were close friends of Jung, insist that he wholeheartedly supported the Jews as best he could during this horrible time (Clarke, 1992; Ellenberger, 1970; Jaffé, 1971).

Although Jung retired in 1946, he continued to give talks and travel the world and was particularly interested in visiting tribal cultures in his effort to better understand universal symbols and the collective unconscious. In his later years, he became increasingly interested in the relationship between the psyche and such things as the paranormal, psychic phenomena, and unidentified flying objects (UFOs), often suggesting that such experiences were unconscious projections but sometimes alluding to the possibility that they were real (Lachman, 2010, 2015). After his wife died in 1955, he became increasingly reclusive. In 1961, he died in his home in Switzerland. During his life, he authored hundreds of papers and books, most of which are documented in the 21 volumes of the *Bollingen Series of the Collected Works of Jung* (Read et al., 1959). His most famous books include *Psychology and Religion* (1937), *The Undiscovered Self* (1957), *Man and his Symbols* (Jung & von Franz, 1964), and his autobiography, *Memories, Dreams, Reflections* (Jung & Jaffé, 1961).

View of Human Nature

Jung believed that childhood influences affect our psychological makeup and determine how we consciously view the world. Symptoms, thus, represent a desire to regain parts of self that have been lost to the unconscious (Gabrinetti, 2015). By expanding our consciousness (i.e., revealing unconscious material to consciousness), an individual can integrate parts of the *Self* that have been pushed into the unconscious, as well as primordial parts of the self that have never been revealed to consciousness, and become a more fully functioning, "whole" person.

Although Jung believed that sex could be a powerful motivator, in contrast to Freud, he insisted that it was no more powerful, and sometimes less so, than many other drives, including the drives for power, ambition, envy, fanaticism, revenge, hunger, creativity, self-reflection, activity, and spirituality (Jung, 1969b). Also, in contrast to Freud, Jung believed that sexuality and other instincts could play a significant symbolic nature in people's lives. For instance, whereas Freud saw incest as being driven by one's id, Jung believed that incest dreams and fantasies represented a longing to go back to an unconscious "animal" state, whereas individuation marked separation from mother and family—separation and growth.

> So long as the child is in that state of unconscious identity with the mother, he is still one with the animal psyche and is just as unconscious as it. The development of consciousness inevitably leads not only to separation from the mother, but to separation from the parents and the whole family circle and thus to a relative degree of detachment from the unconscious and the world of instinct. (Jung, 1957, p. 235)

Splitting from many of his contemporaries, Jung suggested that the psyche consists of our *conscious*, or all of which we are aware; our *personal unconscious*, which contains our thoughts and behaviors that we have experienced but don't remember; and the *collective unconscious*, which houses primordial images called *archetypes* (Jung, 1936). Jung hypothesized that archetypes are inherited by all people and provide the psyche with its tendency to perceive and act in the world in certain ways that we identify as "human" (some examples of archetypes include: the mother, father, hero, caretaker, rebel, creator, and on and on). Evidence for archetypes, said Jung, can be found in the similar behaviors, myths, symbols, and artwork that is found in all cultures.

Jung stated that consciousness develops soon after birth and is related to how each of us uses the *mental functions* of *thinking*, *feeling*, *sensation* (*sensing*), and *intuition* (*intuiting*). In addition to the mental functions, Jung suggested we are born with the *attitudes* of *extraversion* and *introversion*, although there is an innate tendency to favor one (Jung, 1971). As children, Jung suggested

we develop an *ego*, which manages our mental functions and attitudes and allows continuity of our basic personality structure with the possibility that change can occur relatively slowly over time. Based on which mental functions are favored, the ego sorts experiences into those that will be maintained in consciousness and those that will be diverted to the personal unconscious. The way our mental functions and attitudes divert experiences into consciousness or the personal unconscious, Jung called the individual's *character* or personality (Ekstrom, 1988; Jung, 1954).

Jung often used the Chinese symbol for *Tai-chi-tu*, or *yin yang* (female/male), to convey his ideas about mental functions (see Figure 3.2; Jung, 1976; Pascal, 1992). The symbol suggests that the only constant in the universe is change, and we must learn to be in harmony with change. The symbol also suggests that opposing forces in the universe complement one another and merge over time (e.g., female merges with male and male with female).

Inverting the symbol, with the top part representing consciousness, and the bottom representing the personal unconscious, Figure 3.2 shows how the mental functions might be configured if the "thinking" mental function was primary (favored), the "feeling" function was inferior (secondary and mostly unconscious), and intuition and sensation hovered somewhere between consciousness and unconsciousness. Over time, if the person works on uncovering repressed parts of the self, their feeling mental function begins to merge with the thinking mental function and the sensing with the intuitive, thus making us more whole.

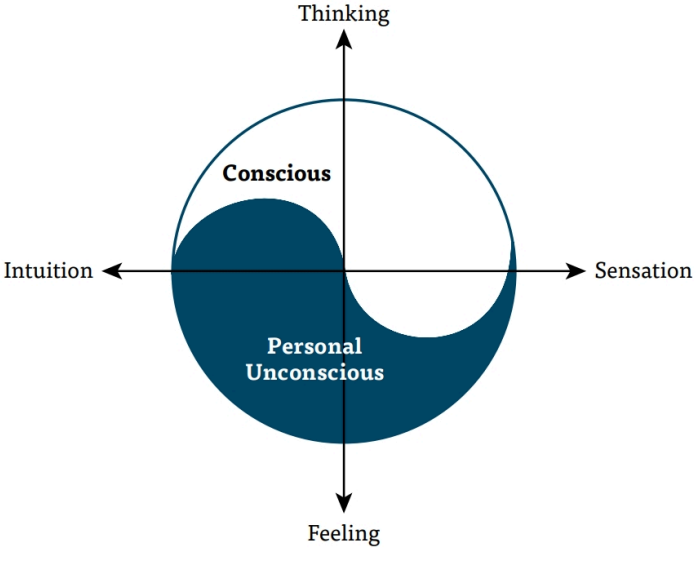


FIGURE 3.2 Tai-chi-tu Symbols. Left: tai-chi-tu (yin yang) symbol. Right: inverted Tai-chi-tu, showing mental functions and psyche relationships. In this example, "thinking" is in consciousness.

In addition to the mental functions, Jung suggested that archetypes are constantly impinging on us in mysterious and unconscious ways and provide energy for what he called *complexes*. For example, a father complex could evolve within an individual who has been physically abused by his father. The abuse, which is repressed, still "lives" in the personal unconscious and becomes attached to the archetypal image of the father, becoming a complex. This complex then impinges on the waking life of the individual; perhaps, the individual becomes angry toward all male authority (father) figures.

Jung believed that the person is born whole, with all the ingredients necessary to embody a fully functioning human being. However, because there is a tendency for one or more mental functions to take priority, because we build complexes, and because we repress traumatic experiences, an

individual's psyche will often become damaged or split and develop unconscious personalities that act almost like separate functioning individuals. The goal of therapy, said Jung, is to become whole by discovering parts of the *Self* that have never been experienced, aspects of Self that have become repressed, and portions of Self that have been split off. Thus, if I am more of a thinking type, it would be important for me to become in touch with my "feeling" side. And if I'm more of an extravert, I should try to find the introvert part of me. If I have repressed memories and complexes, I should attempt to get in touch with them. Jung called the development of consciousness about our mental functions, attitudes, complexes, and repressed parts of self *individuation*. This individuation process, Jung believed, develops over time if the person is in an atmosphere that encourages wholeness and is critical if we are to live in a civilized world that thrives on healthy relationships (Gabrinetti, 2015; Jung, 1971; Lachman, 2015).

Key Concepts

Some of the key concepts that underlie analytical therapy include psychological types, which encompass the attitudes and mental functions; the psyche, including the conscious, personal unconscious, and collective unconscious; archetypes, including the persona, shadow, anima/animus, and the Self; complexes; individuation; symbols; and synchronicity.

Psychological Types

After years of self-reflection, Jung (1921/1964a) wrote a book based on his belief that that there were two *attitudes* and four *mental functions* that described an individual's major ways of processing information and making sense of the world (Casement, 2015; Lachman, 2010, 2015). The attitudes, which included *extraversion* (E) and *introversion* (I), oriented one to the outside objective world or to the internal subjective world. The functions are the ways in which we operate in our outer or inner world and include *thinking* (T), *feeling* (F), *sensing* (S), and *intuiting* (N). Jung believed one is born with a tendency to be extraverted or introverted. Crossing one's tendency toward extraversion or introversion with the four functions produces eight possible combinations or *psychological types*.

By the way, if this sounds familiar, it's probably because you have come across the test known as the *Myers–Briggs Type Indicator* (MBTI). After reading Jung's (1921/1964a) Psychological Types, *Katharine Briggs* and her daughter, *Isabel Briggs Myers*, became fascinated with Jung's typology of people. They ultimately added a fourth dimension to Jung's factors, which they called *judging* (J) versus *perceiving* (P) and developed this very popular instrument, often used in personality assessment and career counseling (Neukrug, 2020; The Myers & Briggs Foundation, 2022). The following examines the original two attitudes and four functions Jung identified.

The Attitudes (Introversion and Extraversion)

Are you self-reflective, an observer, more withdrawn than interactive, and think a fair amount about life's meaning and how you fit into the world? If that is the case, you are probably an introvert. On the other hand, if you tend to be social, outgoing, and more interested in objects and people than internal thoughts and feelings, then you are likely an extravert. Jung suggested that one is born with a tendency to be one or the other, although over a lifetime, one's attitude can change. He also suggested that people tend to be conscious of their predominant attitude and that the opposite attitude largely operates out of one's unconscious. So the individual who is a social butterfly and concerned about the outside world will unconsciously focus upon internal aspects, which will be evidenced in the kinds of dreams the person has and other symbols in the person's life (e.g., the kinds of movies a person might like or pieces of art one might pick).

The Mental Functions (Thinking, Feeling, Intuiting, and Sensing)

Jung identified four mental functions, which he grouped into two pairs. The thinking and feeling functions were considered *rational functions* because people use them to make decisions on evidence gathered. The thinking type evaluates or judges information from a detached perspective and uses logic, reason, and the examination of data and causal relationships in this process (consider the stereotypic scientist or behaviorist). Feeling types make decisions by evaluating or judging situations using empathy, by understanding relationships, and by considering the needs of people. Feeling types should not be confused with those who make decisions based on feelings or affect.

Contrast the thinking and feeling types with the *irrational functions* of the sensing and intuiting types. In these cases, information is gathered and understood through one's perceptions. Sensing involves making sense of information that is derived from the five senses: hearing, seeing, smelling, touching, and tasting. Intuition involves making sense of abstract information that is derived from the "gut" and unconscious (e.g., sensing type: "I can smell your lover's perfume" versus intuitive type: "I just know that you're having an affair—I just have that gut feeling").

People tend to favor one of the four functions, and this is called the *primary function*. Whatever one's primary function is, its complementary function in the pair is called the *inferior function*, which resides mostly in the unconscious. Thus, if my primary function is feeling, my inferior function is thinking. The inferior function longs to be "heard" and can provide great information about an individual's unconscious. The second pair, which does not contain the primary or inferior functions, comprises the secondary functions. Of these, one is generally favored because one cannot think and feel or intuit and sense at the same time. The secondary functions hover between consciousness and unconsciousness (see Figure 3.2).

The Eight Types

Pairing each of the two attitudes with the four possible combinations of mental functions leaves one with eight possible psychological types. Figure 3.3 shows the four possible combinations of mental functions, each of which could be matched with an extraverted or introverted attitude—yielding the eight types. Remember, Jung hypothesized that whatever your predominate type is, the complementary type resides in your unconscious and longs to have its voice and become developed. As a person becomes more individuated, they can bring all eight types into consciousness and can use all types at different times (see Box 3.2).

BOX 3.2 Your Psychological Type

Below are the eight possible psychological types. In pairs or small groups, describe the personality type of each of them. Which type do most people tend to drift toward within your class? Helpers tend to have a psychological type of INF. If you are that type, you fit right in with counselors and related mental health professionals. If not, no problem. First, there are all different kinds of helpers, and second, it's good for the "group" to have some differences within it. Wouldn't life be boring if everyone was the same type?

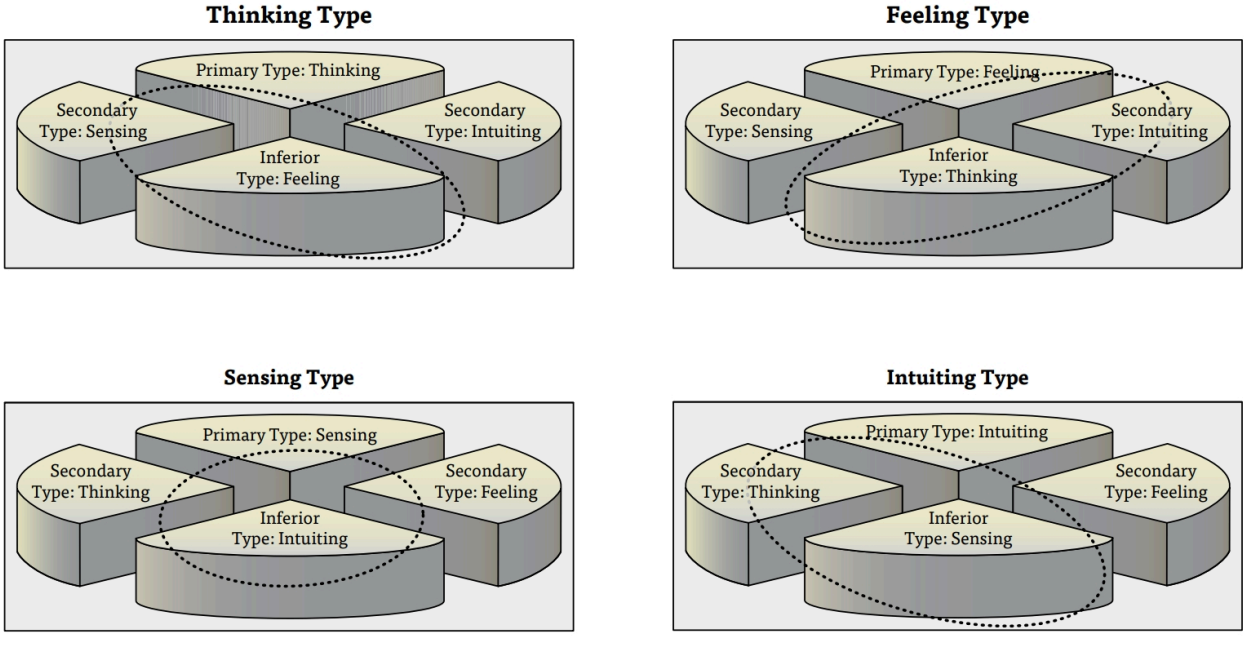
INT INF IST ISF ENT ENF EST ESF

If you remember, Isabel Briggs and Katharine Myers expanded Jung's ideas and added "judging" (J) and "perceiving" (P) mental functions, thus extending the possible psychological types to 16. Using their understanding of psychological types, the counselor type would be INFJ. There

are several free, online assessment instruments you can take to discover your Myers–Briggs type. However, keep in mind that "free" often means an assessment's validity is not as reliable as a well-researched instrument that you would pay to take.

Here's a quick definition of INFJ. Does this describe you?

> INFJ. Seek meaning and connection in ideas, relationships, and material possessions. Want to understand what motivates people and are insightful about others. Conscientious and committed to their firm values. Develop a clear vision about how best to serve the common good. Organized and decisive in implementing their vision. (The Myers & Briggs Foundation, 2022, para. 3)



*Inside the elliptical figure represents unconsciousness and the outside, consciousness. The first example, in the top left corner, shows a person who is primarily a thinking type person (consciousness is largely, but not totally, of a thinking type and minimally of a feeling type. This is visually shown by the elliptical covering much less of the thinking type as compared to the feeling type. In this same example the inferior function is more intuitive than sensing (more consciousness in intuitive realm—outside of the elliptical). Can you identify the primary and secondary types of the rest of the examples?

FIGURE 3.3 The Four Types of Mental Functions

The Psyche

For Jung, the *psyche* represented all our psychological processes and contained all that is in consciousness, the personal unconscious, and the collective unconscious (Gabrinetti, 2015; Lachman, 2015). Like Freud, Jung believed consciousness to be the tip of the iceberg (see Figure 2.3), representing only a small piece of the psyche. However, unlike Freud, Jung had a very different view of the unconscious, which he said consisted of both a personal unconscious and a collective unconscious. Jung also suggested that archetypes, one aspect of the collective unconscious, can seep into our personal unconscious and affect many aspects of our day-to-day behaviors.

Consciousness

Jung defined *consciousness* as all of what we are aware—all of what we know. Consciousness is when the individual can identify a feeling, recognize an experience, consider a fact, or reflect on Self. It evolves out of unconsciousness, as we are born unconscious but are hardwired to develop a sense of "I" at birth, perhaps even before birth, when the infant has their very first encounters with and recognition of objects outside of self. For instance, watching a newborn seek out their mother's breast is clearly an instinctual act, while at the same time, it is the early beginning of consciousness, as awareness of the Self, and their mother as separate from the newborn's Self, begins. The *ego,* which is sometimes used to describe the self-conscious "I," mediates what will come into consciousness.

By age eight or nine, the ego is largely intact and acts as filter to experience, allowing only those experiences that match the individual's psychological type to remain in consciousness (e.g., introvert–thinking–sensing type: ITS). What causes the ego to allow only certain information to remain in consciousness? Probably, a combination of genetics that tends to orient us toward a certain way of acting (e.g., extraversion or introversion) as well as environmental factors, such as parents, who reinforce certain ways of living in the world (stressing the importance of one mental function over another). For instance, a child born with a genetic tendency toward introversion might also have parents who reinforce the "feeling" and "intuitive" mental functions. This results in an introverted child who is a "feeling type" with a secondary intuitive function. This person's psychological type is introversion, feeling, and intuition (IFN).

As the child grows into adulthood, the ego can be expanded, as the mental functions and the attitude that have not had a voice are experimented with and integrated into consciousness. Expansion of ego consciousness and psychological maturity was called *individuation* by Jung. As a quick example, a person who has developed an ego that lends itself to an extroversion, feeling, and sensing (ESF) psychological type can begin to experiment with their introversion, thinking, and intuiting self. Since each of us has various levels of attitudes and mental functions (e.g., some people are extremely extroverted, and others are only slightly extroverted) and because there are eight combinations of the attitudes and mental functions, there are an infinite number of personalities—although, some are clearly more alike than others.

While the ego only allows experiences that match one's psychological type to come into consciousness, the ego is also being affected by the inner world from the unconscious. Thus, the ego can be invaded, possessed, and taken over by complexes that have been formed in the personal unconscious (Bibbee, 2006). In fact, one's conscious understanding of Self may not always match behavior, such as the jealous lover, who has little awareness of their passive-aggressive behaviors. When asked about their feelings toward their lover, they describe their lover as "the love of my life" and denies other motivations to their behavior. This is why Jung (1966a) said, "Generally speaking, therefore, an unconscious secret is more injurious than a conscious one" (p. 53).

Jung believed that, over time, especially in the second half of our lives, the ego could expand and allow additional information to flow into consciousness, thus allowing ourselves to experience the various ideas, feelings, memories, and perceptions that have not been allowed into consciousness—that have been repressed. However, even as the ego is expanded, there are always more hidden areas. Stand on the top of the Empire State Building, and you can see a lot more than you could when you were standing on the street; however, if you didn't know better, you might think that all of what you see is all there is:

> What the ego comprehends is perhaps the smallest part of what a complete consciousness would have to comprehend. (Jung, 1969b, p. 324)

The Personal Unconscious

The *personal unconscious* houses all material from an individual's unique experiences that have been filtered out of consciousness and repressed into unconsciousness. In contrast, inherited universal unconscious material can be found in the collective unconscious (discussed in the next section). Believing that all of life's experiences are remembered or have the potential to be remembered, Jung asserted experiences incongruent with an individual's psychological type are diverted to the personal unconscious—in a sense, waiting to be discovered if afforded the opportunity. For example, unconsciously, the feeling-type person's ego diverts the thinking part of self to the personal unconscious; the intuiting person's ego diverts the sensing parts of Self to the personal unconscious; and so forth. In addition, traumatic experiences may be repressed and housed in the personal unconscious. However, through personal discovery, such as that which occurs in psychotherapy, all diverted and repressed parts of Self can be rediscovered.

> The total material that is added to consciousness causes a considerable widening of the horizon, a deepened self-knowledge which, more than anything else, one would think, is calculated to humanize a man and make him modest. (Jung & Campbell, 1928/1971, p. 80)

In considering the proposition that all can be remembered, think of individuals who have had a near-death experience and, in a fleeting moment, are said to remember all aspects of their lives as it flashes by them. It is as if their personal unconscious, in that moment, floods consciousness. So all those experiences, along with complexes associated with them (which will be expanded upon later), are held in the personal unconscious and impinge upon conscious behaviors. A major goal of psychotherapy is to assist the individual in becoming more aware of the personal unconscious and to integrate the various split-off parts of Self into consciousness. This, said Jung, is one piece of what leads us toward becoming whole. However, Jung also believed there was much more unknown that was housed in what he called the collective unconscious.

The Collective Unconscious and Archetypes

Perhaps, the most interesting aspect of Jung's theory was his belief in a *collective unconscious*, sometimes called the *impersonal unconscious* (Bennet, 1961; Jung, 1936). Although the concept of an unconscious had been around with Freud and others (Hall & Nordby, 1973/1999), it had always been associated with repressed material that was the result of actions that occurred after birth (e.g., a traumatic event). Jung, however, suggested that such repressed material was housed in the personal unconscious, and a separate, collective unconscious held an additional function. A product of the evolutionary process, Jung believed the collective unconscious is inherited, identical in all of us, and contains the archetypes, which provide the psyche with its tendency to perceive the world in certain ways that we identify as "human." Evidence for archetypes, said Jung, can only be inferred and is found in the similar behaviors, artwork, images, and myths that are recognized in all cultures.

> In addition to our immediate consciousness, which is of a thoroughly personal nature and which we believe to be the only empirical psyche (even if we tack on the personal unconscious as an appendix), there exists a second psychic system of a collective, universal, and impersonal nature which is identical in all individuals. This collective unconscious does not develop individually but is inherited. It consists of pre-existent forms, the archetypes, which can only become conscious secondarily and which give definite form to certain psychic contents. (Jung, 1968a, p. 43)

The scope of potential behaviors reflected by the archetypes is wide and depends on the psychological type of the person and the kinds of repressed events that have impinged on the individual.

For instance, the "mothering" archetype is the innate energy that all of us have toward nurturing and caring for children. How that gets actualized in an individual will vary, as a function of psychological type as well as important events that have affected an individual. Jung believed that all individuals have the same archetypes that impinge on them in unconscious and mysterious ways, unless, that is, they can become conscious of their influence through the process of integration and individuation.

In traveling the world, Jung found an array of similar myths, symbols, behaviors, and artwork that reinforced his belief in archetypes. Archetypes provide the form for our understanding and the images we hold related to birth, rebirth, death, power, magic, the hero, the child, the trickster, God, the demon, the wise old man, and the Earth mother, to name just a few. From culture to culture, we see similar stories, myths, and artwork that explain these concepts, said Jung. For instance, the Romans projected their power and fear by creating Jupiter, their sensuality through the formation of Venus, and their suspicions about the unknown by creating Neptune (the unconscious?). Today, we still project our archetypes, representing our hidden parts of selves, onto such things as the heroes we invent in our movies (e.g., Superman), the "evil-doers" we identify in the world, the football games we cheer for, or the people we idolize (e.g., Mother Teresa). In actuality, the hero, evil, our competitive parts, and our nurturing parts may all be hidden parts of ourselves, having their origins in our archetypes and resting comfortably in our personal unconscious, if not acknowledged in consciousness (see Box 3.3).

BOX 3.3 The Hero Within

I (Neukrug) remember when there was a plane crash in Washington, DC, during the winter. A man who saw the plane go down rushed to a bridge right near the crash and jumped into icy waters to save some of the passengers. What a hero, I thought. But what made this man, who had never done anything particularly heroic, suddenly do this at that moment? Jung would say, it is the hero within and that we all have this. Like the time when I was just married and on a pier with my wife: Suddenly, I saw a pelican with hook and line hanging from his beak. I reached out, held his razor-sharp beak, and cut off the line to save the bird's life. Or the time I suddenly performed the Heimlich maneuver, which I didn't think I knew how to do, on my then-choking seven-year-old daughter, whose life I saved. The hero is within us all, and at times, it can show itself. As we grow and mature, we can nurture it and have it become more prominent.

Although there are a limitless number of archetypes, there are four that have become particularly well-known and important to the makeup of the individual. In order of their embeddedness to the unconscious (or closeness to consciousness), they include persona, shadow, animus and anima, and Self (Gabrinetti, 2015; Jung, 1936).

Persona

Several years ago, I (Neukrug) took a five-day workshop with Sid Simon, one of the founders of the values clarification movement. At that workshop, we were asked not to reveal our occupation or the degrees we held. Working on my doctorate, I quickly realized how much of my identity was based on presenting myself as a potential "Dr." in the field of counseling. This very humbling experience helped me see the importance the masks we wear play in defining who we are in our conscious lives. That mask, said Jung, is the *persona*.

The persona is our façade—the part of us we show to the world, while masking other aspects of ourselves from others and, sometimes, even from ourselves. It helps us get along with one another, and indeed, we probably would be a pretty chaotic society without it. We may even present a

different persona throughout the day. For instance, I wake up and have my "father" persona on; a little later, I wear my "work" persona; and at some points in my day, I likely wear my "social" and my "spousal" persona. Some people get so caught up in their persona that they lose track of who they are underneath their mask. Jung believed that the part of individuals being hidden by the persona yearns to be realized and will be shown to them in their dreams and in other symbolic ways in their life. Relatively easy to gain consciousness of, it is not surprising that in both individual and group counseling, one of the first things clients gain awareness of is how they are "fake" in different parts of their lives and the various personas they wear to "get through" the day. Although the persona can be an aspect of our "fake" selves, it also represents the amount of Self we choose—sometimes wisely—to reveal to others.

Shadow

The *shadow* archetype reaches out of the collective unconscious and lurks behind many aspects of the Self: it is all of what we are not in our conscious lives. If I (Neukrug) am extraverted, it is my introverted Self, and if I am a thinking type, then it is my feeling side. If I am male, it is my female Self, and if I am female, it is my male Self. If I am loving, it is the part of me that hates, and if I am hating, it is the part of me that loves. It may include what many might view as a pleasant side of humanity (e.g., the sensitive side some may be fearful of showing) and, yet, often will hold our darkest secrets, our shameful behaviors, our murderous thoughts, and our most devilish selves. We are alive because of it, for without a shadow, we cannot be fully human.

Anima/Animus

Based on a binary conceptualization of gender, Jung noted that individuals have an inner "gender opposite" that calls them. A man's inner opposite is *anima*, and as a woman, it is their *animus*. A gender-opposite side relates to those attitudes, feelings, and behaviors that do not typically conform to gender role socialization or gender identity (e.g., a man expressing "female" emotions or a woman demonstrating competitive and authoritative behaviors). The anima, or the female part of the male Self, seeks to define a person who identifies as male in ways that are opposed to its animus counterpart, and vice versa for those who identify as female. This unconscious process can create a state of tension for gender identity development. However, to be fully human means that one allows oneself to be in touch with and accept the opposite within.

The Self

Symbolic of "the God within us," the *Self* represents the unity of consciousness and unconsciousness. Because consciousness expands with age, the Self is always changing as individuals integrate different parts of themselves into consciousness. The Self has to do with what a person is becoming and is closely related to the process of individuation (discussed later). In a young person, the Self is egocentric, focused mostly on consciousness. However, as a person ages, grows, and deepens, they see the parts of themselves that have been split off. First, our shadow becomes our partner, then our anima or animus becomes known and embraced. The Self does not seek to be "better" or to be "perfect"—it seeks to be complete, integrated, and whole.

Jung found that as clients move toward wholeness by integrating unconscious aspects into consciousness, they often draw increasingly complex representations of art that approximated the Hindu or Buddhist *mandala* (see Figure 3.4). A concentric diagram that was used centuries ago to represent the divine, God, wholeness, and existence, the mandala is still used today as a source of meditation, peace, and harmony and to indicate one's search for completeness. Each person's mandala is, of course, unique and symbolic of their own path toward wholeness.

Complexes

> [A complex] has a sort of body, a certain amount of its own physiology. It can upset the stomach. It upsets the breathing, it disturbs the heart—in short, and it behaves like a partial personality. (Jung, 1976, p. 72)

Imagine if you were not "you" but instead were a number of "yous." This idea was basic to Jung's theory and brings us to his concept of *complexes*. If you remember from earlier in the chapter, Jung found evidence for complexes in the reactions that individuals had to a word-association test. He found delayed or unusual responses (i.e., tics) to certain words usually meant that those words seemed to fit into a logical grouping, which he called a "complex." For instance, imagine how one might respond to the following words if verbally and physically abused by a mother or father: hand, voice, eyes, hit, mother, father, and parents.

FIGURE 3.4 Mandala

Jung believed that there are an indeterminate number of potential complexes, which are formed from repressed material and fueled by our archetypes. What gets repressed? Any experience that is not congruent with one's psychological type as well as material that we want to forget (e.g., abuse, shame, intensely negative feelings, and traumatic events). Repressed material of a similar nature gets clumped together, said Jung, and becomes a complex which gets its energy from an archetype of a similar nature.

Although one can have many "complexes," some may become prominent (Jung, 1976), and complexes are not necessarily pathological, such as when the mother complex is formed out of many traditionally positive women's instincts. However, in some cases, complexes become walled off and create a separate personality that does not serve the person well, such as when a woman's maternal instincts are focused exclusively on child rearing to the exclusion of a relationship. Finally, sometimes complexes can be fueled by more than one archetype. For instance, the bully might get its psychic energy from the trickster and power archetypes (see Box 3.4).

BOX 3.4 The Bully Complex

Imagine a young child who is verbally intimidated and physically abused by his or her parents. As a function of the child's psychological type, certain feelings of anger, shame, rage, revenge, and hurt, as well as the memories of being brutally physically abused, may become repressed. Ultimately, such feelings and remembrances linger in unconsciousness and become attached to one or more archetypes, creating a complex. What archetype might become attached to such feelings? Perhaps, the trickster and power archetypes. These archetypes served a survival mechanism thousands of years ago when being manipulative and powerful might have been

critical to physical survival. Today, they become "bound" in a personality style, called the "bully complex." This complex allows the bully to get through the day without experiencing those horrible feelings and remembrances. However, it comes with a price, for it prevents closeness and can wreak havoc on people the bully knows and even on society. However, there is hope for the bully. Through self-examination, the bully can begin to understand the repressed parts of self and how they became associated with the trickster and power archetypes. But this is not an easy task, for it means bearing witness to some difficult and shameful memories. However, if the child and growing adult do not examine these aspects of Self, the child will grow into an adult who will likely continue to bully and may become a "gangster." Gangsters treat their children like they were treated—and the cycle continues.

Organization of the Psyche

Figure 3.5 shows the relationship between the collective unconscious, where the archetypes are held; the personal unconscious, which houses our repressed memories and our complexes; and consciousness. The four most popular archetypes of the Self, the anima or animus, shadow, and persona are noted, as well as the ego, which is considered by some to also be an archetype. The relative positions of these archetypes represent how close each is to consciousness and the relative ease at which our conscious minds can understand these aspects of Self.

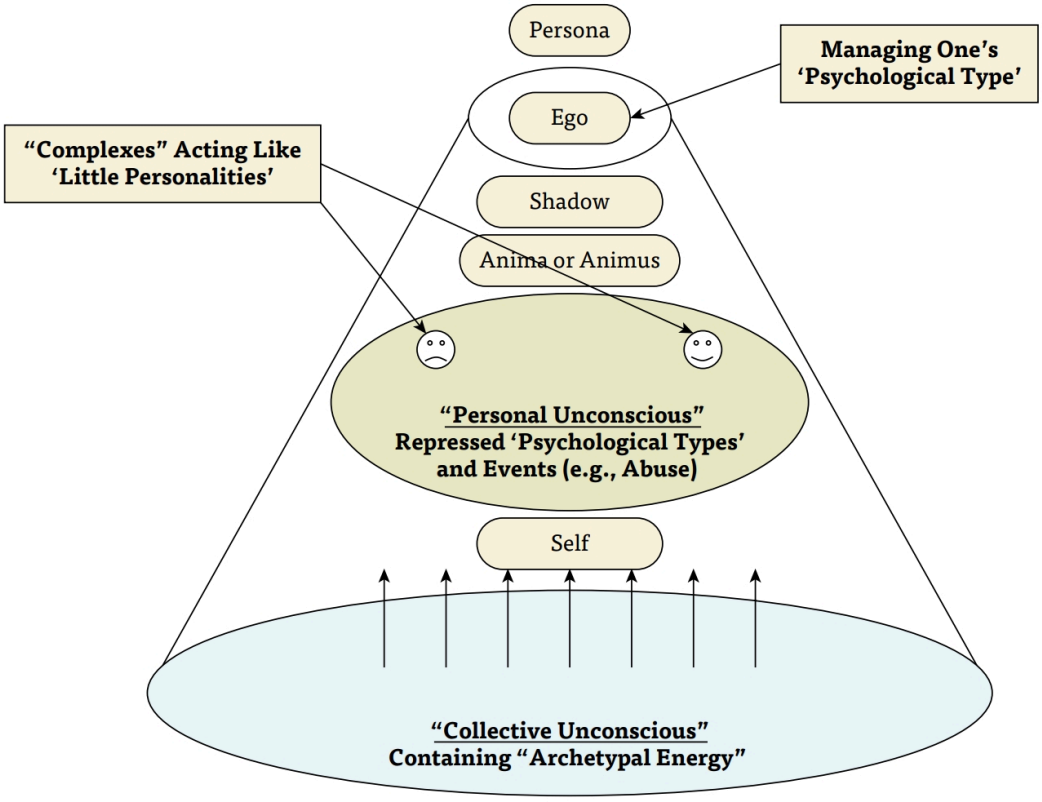


FIGURE 3.5 Organization of the Psyche

Individuation

Individuation is the lifelong process of becoming conscious of the many separate and hidden parts of Self, with the goal of integrating the various parts into the whole person. Individuation is not inevitable but can be facilitated by an environment that is safe and encouraging of self-reflection. It includes the integration of all that is conscious with all that is unconscious and is closely aligned with an increasing awareness of Self and movement toward wholeness and completeness. In other words, as we grow, and if given the opportunity to broaden our consciousness, we can begin to understand our unique psychological types, our complexes, and the archetypes that make up who we are. Who are those who are most individuated? Jung suggested Buddha and Jesus. We might add Gandhi, Eleanor Roosevelt, and Martin Luther King, Jr.

Symbols

> What we call a symbol is a term, a name, or even a picture that may be familiar in daily life, yet that possesses specific connotations in addition to its conventional and obvious meaning. It implies something vague, unknown, or hidden from us. (Jung, 1964b, p. 20)

Symbols represent or stand for something else. Thus, the manifest, or obvious meaning, of a trophy is that it is symbolic of an accomplishment. Freud would likely have seen a trophy as also having a latent meaning—perhaps, representing a phallic symbol and the underlying id wanting to show its "manhood" (e.g., "My trophy is bigger than yours"). On the other hand, Jung would more likely see the trophy as the symbolic yearning to become something greater than individuals are—a yearning for completion and wholeness.

Jung believed that many symbols are projections of archetypes from the collective unconscious and suggested that similar symbols are found in all cultures (Jaffé, 1964). For instance, the symbol of the circle appears in early mandalas drawn by Tibetan monks, on cathedral floors in the Middle Ages, on Native American petroglyphs (i.e., rock carvings), in primitive artwork representing sun worshipping, and in ancient architectural plans of cities. These drawings often had concentric circles leading to the middle and seemed to represent the desire for wholeness as one works toward finding one's center. And just about all ancient and modern-day religions have used live animals, drawings and figures of animals, or stories about animals as symbolic messages of the instinctual (i.e., animalistic) nature of people that is generally split off from the more conscious aspects of the psyche, which tends to see itself as civilized and virtuous:

> [T]he relationship of these two aspects of man is beautifully symbolized in the Christmas picture of the birth of Christ, in a stable among animals. (Jaffé, 1964, p. 238)

Jung believed that symbols in a person's life have their origins in archetypes, are viewed through and transformed by the individual's unique psyche, and represent an important part of self that needs to be acknowledged and integrated on our way toward wholeness. Therefore, they can hold different meanings for different individuals yet, due to their relationship to the inherent nature of archetypes, often bear resemblance to symbols found in antiquity and in different cultures:

> Jung told the story of a schizophrenic patient who spoke to him one day in 1906 in a Zurich hospital. The patient said that if he looked up at the sun and moved his head from side to side, he would be able to see the sun's penis wagging to and fro, producing all the winds on our planet. Four years later Jung happened to read a newly discovered two-thousand-year old Greek text describing a ritual and initiation into the worship of Mithras, the Sun-god of ancient Persia. According to the text, the initiate was to move his head from side to side to observe the sun's phallus producing the east and

> west winds on earth. The schizophrenic Jung spoke with could not have consulted this newly unearthed ancient text before recounting his own version of its content to Jung. (Pascal, 1992, p. 94)

Symbols are continually found in our lives, and as individuals become more conscious, they can make sense of them. They are in the artifacts and stories of our religions and represented by the types of jobs individuals pursue, style of clothes they wear, types of cars they buy, dreams they have, and on and on. In the end, much of one's life is a symbolic life, and the more individuals can become conscious of their symbols, the more aware they become of the Self and move toward wholeness.

Synchronicity

Jung often walked a fine line between his belief in modern-day science's focus on external reality and the idea that the world only made sense if one suspended left-brain (logical) thinking (Lawrence, 2000). When it came to the concept of synchronicity, this line was as thin as ever. Jung saw *synchronicity* as a reflection of a psychic event happening while a physical event occurred—the two events having some meaningful relationship to one another, and there being no causal relationship between the two (Wood, 2015). This meaningful coincidence provides fodder for an individual understanding their Self more deeply.

As an example of synchronicity, Jung tells a story about a client with whom he was making little progress. During a session with a woman who was staunchly based in rational thought and not allowing herself to delve into the unconscious, she started to talk about a dream in which a piece of jewelry, in the shape of a golden scarab, was given to her. At that very moment, Jung heard something tapping on his window and looked over and saw a scarab beetle, which he let fly into his office. He caught the beetle, which looked remarkably like the one in her dream and handed it to the client, while saying: "Here is your scarab" (Jung, 1969b, p. 526). The scarab, which represents a rebirth symbol, was used by Jung to help point the client toward a new rebirth of s elf, a rebirth in which she could now visit the irrational and the unconscious. With this event, says Jung, treatment then took off. Although not a "technique" that one uses in therapy, or something that happens on a regular basis, synchronicity provides additional material that can help a client understand the self (see Box 3.5).

BOX 3.5 Symbols and Synchronicity

I've (Neukrug) always wanted to find a shark's tooth. Every summer I go to the beach and spend a week or two walking on the sand looking through all the shells to find a shark's tooth. Then, one summer, I'm sitting on the beach, and my wife says, "What's that under your chair?" I look down and see a 1½" × 1" shark's tooth. I'm ecstatic, finally finding my artifact. I carry it around with me constantly. A week later, she comes up to me and says, "I have something I need to tell you; I bought that shark's tooth and put it under your chair." I was shattered and realized my quest had to continue.

A few weeks later, I'm preparing my lecture on analytical psychology and reviewing the section on symbols, when a colleague walks in to my office and sees my shark's tooth on my desk. He blurts out, "What's that symbolic of?" I immediately tell him the whole story, and he says, "Well, what's important is not finding a shark's tooth but what it symbolizes."

"Oh yeah," I say to him and to myself, as I reflect on his important statement. Meanwhile, I look at him, and I tell him: "That's synchronicitous. I was just reviewing my section on symbols."

So I go to class with my shark's tooth, and the first thing I do is to hold it up proudly. I show the class my "symbol" and talk about the importance of symbols in our lives and how they are projections of inner parts of our selves. A few days later, one of my students sends me this e-mail:

> I went on a walk with my wife at the beach. We always look for shells, sea glass, and sharks' teeth. My wife is a sixth-grade science teacher, so she brings them into her class to use as examples while doing lessons. Of course, it's really much more common to find good shell and sea glass specimens and, like you, I haven't been able to find a shark's tooth in any of my beach-walk searches. Now for the synchronicity: I was telling my wife your story about your shark tooth obsession, and how you had not been able to obtain one in all of your searches, either. At exactly the same time I was telling her the part of how you were at the beach and you looked under your chair to find your first shark tooth, I looked down and thought I was looking at yet another deceivingly shark-tooth-shaped rock. I bent down to pick it up, only to realize that I was wrong. It was a shark tooth! Me and my wife both looked at each other and confessed goose bumps.

FIGURE 3.6 Shark Tooth

This true story shows a meaningful coincidence and provides me (and my student) with something to think about. I guess I better think some more about what that shark tooth means to me.

Therapeutic Techniques

With the above key concepts in mind, it is not surprising that all techniques in analytical therapy attempt to construct an atmosphere that allows the client to access the unconscious. The following represents a brief review of a few of the more commonly used techniques, including employing a dialectical method, active imagination, using creative techniques, dream analysis, amplification, transference and countertransference, and interpretation (Gabrinetti, 2015; Jung & von Franz, 1964).

Employing a Dialectical Method

Differing from the psychoanalytic approach, in which the analyst is empathic but a bit removed from the client, Jung believed it was critical to employ a *dialectical method* that fosters meaningful dialogue between the client and the psychotherapist. Such a dialogue, said Jung, fosters the "mutual commitment and care that occurs between healer and the healed," as the client explores unknown parts of self in their attempt to heal the soul (Hopcke, 1999, p. 55). This was accomplished by showing acceptance, encouraging dialogue, and gently stressing the importance of introspection (Dry, 1961; Jung, 1966a).

Jung also recognized that the psychotherapist's and client's unconscious selves would interplay within the relationship, which could sabotage client movement toward increased consciousness, especially if the psychotherapist had not made movement toward their own individuation. Believing that clients would intuit a psychotherapist's lack of psychological development, he suggested that psychotherapists should attend to their own psyche, especially for issues of countertransference.

> In any such discussion the question of whether the doctor has as much insight into his own psychic processes as he expects from his patient naturally counts for a very great deal, particularly in regard to the "rapport," or relationship of mutual confidence, on which the therapeutic success ultimately depends. (Jung, 1966a, p. 116)

Active Imagination

Active imagination offers one method to access repressed material, which involves allowing one's unconscious mind to drift, while the conscious mind acts as a nonjudgmental observer. Active imagination is different from hypnosis or dreaming, which is involved solely with the unconscious mind, or the process of imagining a scene, daydreaming, or active directing of fantasies, which are driven mostly by conscious thought.

In doing active imagination, a client usually starts with a significant piece of a dream, thought, or fantasy that seems to have an important "message" to them. Then, they allow the unconscious mind to take the visualization to wherever it needs to go to conjure up the deepest recesses of the mind. In fact, trying to move one's thoughts in a particular direction will often have the result of moving the person away from important repressed parts of self, as the unconscious attempts to protect the individual from painful material. As the process continues, the client is to have an active conversation between the conscious and unconscious minds, in which the conscious mind sets up a conversation with the images and asks such questions as, "Why are you important to me?" "What purpose do you serve for me?" and "What part of my Self is being awakened by you?"

As a client allows themself to access deeper parts of Self, aspects of the persona, and then, the shadow will usually first be accessed, as these archetypes are closer to consciousness and "safer" to access (see Figure 3.5). However, as a client becomes more deeply involved in the active imagination process, aspects of the anima or animus will emerge. After more unconscious and hidden parts of self emerge, the Self, or the subjective sense of all of what we are, becomes clearer. Ultimately, the purpose of active imagination is to uncover repressed and split-off parts of oneself and integrate those parts into the fully functioning person.

Using Creative Techniques

> Whenever the creative force predominates, life is ruled and shaped by the unconscious rather than by the conscious will, and the ego is swept along on an underground current, becoming nothing more than a helpless observer of events. (Jung, 1966b, p. 103)

Since we constantly project our unconscious onto the world, Jung suggested the use of creative outlets for projections could help a client realize their inner unconscious voice. Whether through poetry, prose, use of clay, drawing, painting, or other creative endeavors, if done spontaneously (without conscious control), the unconscious can have an outlet. The results of a creative piece could then be understood as a projection of the client's personal and collective unconscious and, ultimately, integrated into consciousness.

The key to using *creative techniques* is to allow the unconscious to emerge spontaneously. Thus, like active imagination, clients are encouraged to let themselves "go" and allow their creative selves to emerge. There is a scene in the movie *Close Encounters of the Third Kind* in which a character has an uncontrollable urge to create a mountain—out of mashed potatoes, out of dirt, out of whatever is around. Ultimately, the mountain they are creating is in the same shape as the mountain where aliens will land. Symbolically, the mountain they create represents an escape fantasy: Climb the mountain and escape from the day-to-day constraints placed on us by

our ego. And ultimately, we can be whisked away on a spaceship into the universe and discover the unknown—our unconscious. Thus, understanding the metaphoric and symbolic meaning of creative expressions and integrating those unconscious aspects into consciousness is the key to this technique.

Dream Analysis

For Jung, dreams were a mirror that reflect unconscious parts of Self to the ego. In contrast to Freud's interpretation of dreams, Jung believed it was the role of the psychotherapy to facilitate the client's understanding of their dreams, so they could gain knowledge of their unconscious meanings. Whereas Freud believed that dreams held latent meaning that needed to be examined relative to the psychosexual stages and the resulting id and superego conflicts, Jung believed that dreams hold personal and symbolic meanings that can be understood by freely associating to, and amplifying aspects of, the dream (Lachman, 2010, 2015). You might say that, with Freud, you're trying to tear down the dream to get to hidden parts of Self, whereas with Jung, you're trying to expand upon the dream to understand its symbolic unconscious meanings.

In Jungian *dream analysis*, clients are encouraged to remember their dreams by actively trying, such as waking up and saying to oneself, "What did I dream last night?" or by keeping a dream journal. In therapy, clients are encouraged to associate, brainstorm, or amplify aspects of a dream. Jung generally discouraged the interpretation of dreams (e.g., dreams of falling mean giving in to sexual desire), believing that individual meanings vary and that each client could reveal for themself the unique meaning a dream held. However, he was comfortable offering thoughts about and inviting discussion of a dream if he believed it might foster client awareness of the Self (McLynn, 1996):

> Further, I present him with my ideas and opinions. If, in so doing, I open the door to "suggestion," I see no occasion for regret; for it is well known that we are susceptible only to those suggestions with which we are already secretly in accord. (Jung, 1966a, pp. 44–45)

Thus, insights about a dream come from many sources, including the client's unique personal understanding of the dream that may be related to their personal unconscious and the symbolic meanings of the dream that are rooted in archetypes from the collective unconscious.

Amplification

Jung believed in the importance of clients amplifying symbols found in all aspects of their waking and sleeping lives in an effort to understand the many meanings they hold. In this process, the therapist is trying to uncover what meaning symbols hold relative to material that is stored in a client's personal and collective unconscious (e.g., meanings derived from archetype). To help facilitate the process of *amplification*, Jung recommended using "suggestion, good advice, understanding, sympathy, encouragement" (Jung, 1966a, p. 173), and other techniques that could gently help the client examine the multiple meanings of a client's important symbols, dreams, artwork, daydreams, fantasies, and so forth.

For instance, as a child, I (Neukrug) had a recurring dream that I was walking on a concrete path parallel to the ocean. As I walked, I saw piers with skulls hanging on wooden entranceways. The dreams followed heart disease I had between the ages of 8 and 13. Table 3.1 shows just a small sample of some of the multiple meanings I might find by amplifying this dream.

TABLE 3.1. Amplification of a Dream

Symbol	Association	Possible Meaning
Myself walking	Ego. The conscious me.	My ego has a glimpse at my personal and collective unconscious, as represented by the pier, skull, and ocean.
Concrete path	Solid and grounded.	I am strong, as long as I remain on this solid path.
Concrete path	Father archetype (the concrete representing my father, who had a construction company).	My father is with me. I am my father and can draw strength from my animus.
Skulls	Impending death.	Annihilation of self. Fear of my being not existing. Dying, literally or figuratively. Can I face my fears?
Skulls	Repressed anger toward parents and God for impending doom and annihilation.	Shadow self. The "not-nice" boy. Being the other part of me. Being free to be angry.
Ocean	The unconscious.	All that is unknown to the ego. I wonder and fear unknown parts of myself.
Wooden pier	Soft wood—shaky, not grounded.	The entranceway to my unconscious mind is shaky and scary.
Long pier	Long walk to the unconscious guarded by the skulls.	The skulls sit at the beginning of the pier warning me to not go toward my unconscious.

Transference and Countertransference

Jung believed that material from the unconscious is projected onto others and deeply affects all relationships (Diamond, 2021; Pascal, 1992). Because parents or guardians form our first, most important relationships, these projections often occur first with them. For instance, the archetype of the hero may be first projected onto a child's caregivers (in their early years, children see them as heroic), and this projection will affect their interactions with their parents or guardians. In psychotherapy, similar projections can occur onto the psychotherapist, and one role of the analytical therapist is to assist the client in understanding these projections through the dialectical process. Jung saw *transference* as a normal part of all relationships, although from a developmental perspective, as one ages, one is more likely to understand and become increasingly conscious of their transference.

As an example of transference, imagine that a woman client views her woman psychotherapist as strong, assertive, competitive, and a person who takes charge. In fact, the psychotherapist has been dialectical, caring, and empathic, and although they may also have these other qualities, they have not particularly shown them in therapy. After a relationship is built, and the client begins to explore their ego, shadow, and persona, they now encounter another aspect of Self—the animus, or the male part of themself. It is at this point that the psychotherapist gently suggests that maybe these qualities the client identifies with the psychotherapist are actually qualities they have in themself—qualities yearning to be heard and embodied. With this suggestion, the client begins to awaken their animus and integrate their male side into their life. Their ego consciousness has now expanded and with this new consciousness comes new behaviors—behaviors that are strong, assertive, competitive, and can take charge. They have moved closer to being whole, as female and male aspects of their being can now be integrated into the whole Self. Remember, according to Jung, male and female aspects of self (animus and anima persona) are within all of us, and generally, the persona that is opposite of the sex you are born is generally restrained by social constructs.

Jung's thoughts on *countertransference* were similar to his thoughts on transference, but in this case the psychotherapist's unconscious becomes projected onto the client. Jung suggested that it is impossible to avoid countertransference and urged analysts to go thorough analysis themselves to limit it (Machtiger, 1982; Sedgwick, 2017). Understanding one's countertransference helps to limit therapist projections and, thus, reduces confusion in psychotherapy. At times, if done carefully, the psychotherapist's countertransference can be discussed with clients to demonstrate how all relationships are replete with projections that can be examined.

Interpretation

Jungians believe it is important for the client, not the therapist, to uncover the client's unconscious content. This increases client responsibility, lessens therapist power, and reduces the likelihood of countertransference. Thus, they do not heavily rely on therapist ruminations or *interpretation*. However, they will suggest how certain aspects of behavior may be indicative of the unconscious. Thus, at moments in psychotherapy when they believe the client is ready to hear feedback, the psychotherapist might suggest such things as how complexes are formed, point out how opposites hide in the unconscious (e.g., the anima for a male client), explain what psychological type the client seems to fit (e.g., thinking type) and how the inferior type is hidden in the unconscious, suggest how the more common archetypes might affect the client's behavior, make suggestions about how certain client interpretations concerning relationships may involve transference, and note how dreams and symbols in the client's life may be indicative of the unconscious. As a function of the psychotherapist's unique style, some analytical therapists may be more directive and offer more specific interpretations, while others may rely on helping the client self-direct the therapeutic process.

The Counseling Process

> One does not become enlightened by imagining figures of light, but by making the darkness conscious. The latter procedure, however, is disagreeable and therefore not popular. (Jung, 1967, p. 265)

As the above quote suggests, Jung believed that the crux of psychotherapy is to arrive at the whole Self, making the unconscious conscious. Which techniques are used to accomplish this can vary; however, their purpose is to engage the unconscious to understand and become aware of split-off and fragmented parts of Self and integrate them into consciousness. Otherwise, said Jung, the unconscious could wreak havoc.

Jungian analysis is usually long-term and has the aim of helping a client become increasingly aware of their unconscious, which often means being open to parts of Self that are "less rational, more ambiguous, and often mysterious" (Stein, 1982, p. 33). Meeting face-to-face one to two times a week, the psychotherapist encourages dialogue while gently directing the client toward examining the unconscious content of their life. As the client feels comfortable sharing in this dialogue, the therapist will increasingly incorporate techniques that explore the unconscious.

As you might expect, therapy moves from the external to the internal, as clients feel increasingly comfortable sharing deeper parts of themselves and looking more critically at what is present in consciousness and hidden in their personal and collective unconscious. Using Figure 3.5 as a model, let us look at how therapy moves from issues that are apparent only in consciousness to awareness and identification of how the personal unconscious affects the individual and, finally, to an understanding of how the collective unconscious affects behavior.

- **Exploring consciousness:** Generally, the client who first seeks counseling is aware only of a small part of their total psyche. Consciousness is limited at this point, and early on in psychotherapy, the client is processing life in a mostly nonreflective manner. With the help of the psychotherapist, the client slowly begins to identify their "psychological type" as well as the persona they present to the world. This beginning awareness brings a very early intuitive sense that "if this is what I am in the conscious world, I wonder what else is lurking in my unconscious world." Although the client's ego-consciousness is limited at this point, soon it will expand, as the ego begins to tap into the personal unconscious.
- **Moving into the personal unconscious:** As the client continues in therapy, they become more self-reflective. This occurs for several reasons. First, the client is feeling increasingly safe with the psychotherapist, who is using a caring, empathic, and dialectical process to gently nudge the client to examine other parts of the Self. Soon, the psychotherapist uses various techniques (described below) to raise awareness that other aspects of the client's Self exist and that there is likely repressed material that can be brought to the surface. The first of this material is, generally, repressed traumatic events (e.g., abuse) or the opposing psychological types (e.g., unconscious mental functions and attitudes).Success with understanding these other parts of Self slowly yields to the adaptation of new behaviors. Thus, other psychological types can now be tried out, and new behaviors can be adapted as catharsis occurs over the remembrance of traumatic events.
- **Dipping into the collective unconscious:** As the client has been willing to explore their psychological types and repressed events, they are not able to dip into the collective unconscious which usually begins by looking at their personas, shadow, and then anima or animus archetypes. Looking at the "dark side" of oneself is not easy, but the client has gained experience with the psychotherapist and is increasingly more trusting of the self-reflective process. Over time, the client is willing to examine and integrate aspects of the shadow and anima or animus, which become part of an expanded ego-consciousness. Eventually, the client is willing to look at complexes that have taken over and "invaded" the client's way of being in the world. Complexes can now be deconstructed, understood, and redefined in ways that are productive for the client.
- **Delving further into the collective unconscious:** Now that the personal unconscious has been explored and the client has dipped into the collective unconscious, they can more fully explore other aspects of the collective unconscious (Jung, 1968b). Filled with an array of archetypes, the collective unconscious affects the person in subtle, yet profound, ways. Understanding aspects of the collective unconscious generally occurs through the awareness of projections in the client's dreams and symbols. Over time, the client can come to understand how archetypes affect the total psyche. Eventually, there is increased ego-consciousness and a deepening sense of the Self archetype and how it operates to unite all aspects of the individual.

Not all clients are ready to go through the full process of Jungian analysis, and generally, the depth of the work for the client and the willingness of the therapist to gently "push" the client, will depend on the client's stage of life. Clients in their first half of life (by age 40, psychologically) tend to focus more on external issues, such as, "How do I define myself in terms of work?" "How do people see me?" "What is my role as mother, father, partner to my lover?" and so forth (Jung, 1966a; McCurdy, 1982). These clients are more likely to discuss obvious issues of which they are conscious, maybe begin to examine some basic issues from their personal unconscious, explore more "surface" archetypes, such as one's personas, but are less inclined to examine in-depth, unconscious content. During the second half of life, they are more likely to want to build an ongoing bridge or openness between their ego and their unconscious, particularly their collective unconscious, so information can freely flow between consciousness and unconsciousness. Acceptance of aspects

of the unconscious that have been repressed and acceptance of Self, even the "dark side" of Self, is the ultimate goal of Jungian analysis and leads to completeness and individuation.

Social, Cultural, and Spiritual Issues

Although analytical therapy has been criticized as limited in its cultural application to women and individuals of racially and spiritually marginalized statuses (e.g., Enns, 1994, 2021; Lachman, 2015; Rowland, 2019; Sherry, 2010), Jung and other analytical theorists offer concepts that can readily apply to psychotherapy with culturally diverse clients. Like other counseling and psychotherapeutic theories, it is critical to keep in mind the societal and cultural context of the time in which a particular theory was developed and how it offers concepts that can adapt over time to serve clients. Let's look at some of the ways in which analytical therapy can be used for culturally responsive practice.

First, analytical therapy was derived and further developed from global encounters that adherents to analytical therapy had, particularly in Africa, Brazil, India, Italy, and the American Southwest (Rowland, 2019). Since Jung's time, understandings of universal images and symbols were informed by these encounters in a way that continues to expand our understanding of analytical therapy concepts. Through these collective global influences, psychotherapists understand that change within the psyche is a function of symbolic and mythic images that are found across all cultures and languages. Thus, concepts such as archetypes and psychological types—and how they influence complexes, individuation, and wholeness—prevail and may be common to all people.

Second, Jung offered a nonreductionistic and developmental approach to developing the whole, individuated Self, meaning that all aspects of the person create the whole and that the whole changes and develops over time. In addition, he suggested the incorporation of those aspects of Self that are not common or universally acceptable, thus being tolerant of differences. For instance, he saw the importance in acceptance of ones opposing parts of self (i.e., animus or anima), suggesting that we examine aspects of self we are not comfortable with, integrate them, and embrace them, which moves us closer to wholeness and an understanding of others who have those aspects of self we have denied to ourselves. With his focus on symbols that permeate a collective (i.e., universal) unconscious and manifest in clients' personal unconscious, the expressions and understandings of these symbols by an individual are both unique to that person and influenced by the context in which they live. Symbols serve as useful in understanding collective knowledge about complex life experiences and can flex as culture changes (e.g., a shark tooth may have a collective symbolic meaning of power and strength, but how power and strength is important to any one person can vary). Finally, archetypes, which are common to our collective unconscious, channel our perceptions and thought processes and parallel our ancestors and others we culturally interact with across time, thus helping us understand the universality of people. For instance, we all have a sense of what the "hero" is (Enns, 2021; Rybak et al., 2000).

Third, with a focus on the importance of the collective, analytical psychotherapists assume that individual psychopathology and mental health do not necessarily originate intrapsychically but result from their collective cultural roots within society. For clients experiencing transition and social marginalization (e.g., refugees; immigrants; Black, Indigenous, and people of color; women), analytical therapy can facilitate connection with others (e.g., spiritual healers, extended kinship networks, and ancestors) to maximize wholeness and mental health. It also has the potential to highlight how society can create disconnection and marginalization, thus helping clients understand that what has often been suggested to them as inherent problems may actually be a function of discrimination and racism in society.

Furthermore, analytical therapy views clients as having the tools they need to be resilient, self-empowered, and their own expert for Self-healing. Thus, it holds that Self-healing is a

natural process of the psyche, is the key to Self-fulfilment, and includes such things as embracing archetypes and balancing polarities (i.e., yin-yang), such as embracing our animus and anima. The role of the psychotherapist is less as an expert of healing and more as a facilitator to activate the client's endogenous healing capacities that continues through their lifelong process of individuation.

Despite the ways in which analytical therapy can be applied in psychotherapy for culturally responsive practice, there have been some criticisms of this approach—particularly related to gender and its development (e.g., Enns, 2021; McKenzie, 2006; Rowland, 2019):

> [S]ome have criticized Jung's concept of male and female development and his ideas on anima and animus, saying it tends to be an outgrowth of his cultural encapsulation, which, at the time, viewed men and women as dichotomous. (McKenzie, 2006, p. 403)

For instance, gender, like sexuality, may be more of a social construction, not exclusively dictated by biology, and subject to change over one's lifespan. In fact, Enns (1994, 2021) noted that the original formulations of many archetypes convey elements of gender bias and dualistic thinking about masculinity and femininity and a function of socialization and power dynamics of our culture. For culturally responsive practice, gender must be recognized as a continuum, and the role of patriarchy in shaping gender development for all clients must be addressed to maximize intergender relationships as well as the individuation process.

Patriarchy, and other cultural phenomena, have a significant influence on one's understanding of gender development (Enns, 2021; Neuman, 1994) and societal pressures to conform to gender expectations, as well as sexism more generally, must be dismantled for psychological growth. Theorists today emphasize the importance of individuals gaining a more complex understanding of gender and the ways in which it can manifest in the personal and collective unconscious and the developing Self. This process can lead to what scholars (Fraser, 2005) have termed *contrasexual consciousness* that stresses the importance of men and women acknowledging the part of themselves that is opposite of their conscious gender identity. To support contrasexual consciousness, counselors and psychotherapists can discuss how culture and gender is transmitted unconsciously and can highlight both the cultural assets and limitations of archetypes, regarding femininity and masculinity, and help clients identify archetypes that are nonsexist or defy gender stereotypes for them (Enns, 2021; Rowland, 2019).

As you might expect, Jung's views on God and religion were as profound as his views on personality and gender development (Kim, 2016; Lachman, 2010, 2015; Sherry, 2010). Analytical therapy embraces spiritual and religious pluralism. For Jung, the spiritual quest reflected a yearning toward meaning and wholeness that is a fundamental drive. Here he argued that the nature of the psyche includes our ego, which embraces values from our learned religions but also includes our God-image archetype, which we come to know later in life. Jung suggested that as our search for self-understanding deepens with age, we must come to grips with the God that we learned about and the God-image archetype that we slowly come to know.

From a cross-cultural perspective, one must ask whether Jung's work is based on some real notion of the psyche or an elaborate, fictionalized system anchored in Western-based philosophy and psychology. Although Jung believed in the cross-cultural universality of some of his theory, such as when he stated that evidence of similar archetypes can be found in all cultures, others have disagreed with this notion (Bishop, 2014; Gross, 2000; Lachman, 2010).

From Jung's perspective, we are all so different, and yet, we are all the same. Outwardly, we may have different values, jobs, looks, ways of interacting, but in the end, we are all connected. We are connected to one another through the common archetypes, which we all hold, and we are connected to the universe and timelessness through unknown and, yet, vital psychic forces. From this inner perspective, we could always understand the "other."

Efficacy of Analytical Therapy

> The goals of psychodynamic therapy include, but extend beyond, alleviation of acute symptoms. Psychological health is not merely the absence of symptoms, it is the positive presence of inner capacities and resources that allow people to live with a greater sense of freedom and possibility. (Shedler, 2010, p. 105)

In terms of outcome research, some therapies are more easily researchable than others. Jungian analysis is not one of them. After all, how does one measure something as elusive as changes in "inner capacities and resources," as just noted by Shedler (2010).

Although analytical therapy has been a therapeutic tradition for more than 100 years, research on the efficacy of this approach is limited. Some organizations have contributed to the efficacy literature, such as The C. G. Jung Institute of San Francisco (www.sfjung.org), which regularly conducts and publishes research in the *Jung Journal*, which it sponsors. Countries where analytical therapy is a frequently practiced clinical method (e.g., Germany, Switzerland, and Austria) are increasingly collecting and reporting data on its efficacy, using consistent measures of therapeutic effectiveness regarding general mental health symptomology, client satisfaction, and other operationalized psychodynamic diagnostics. Scholars across these countries have formed the Societies of Analytical Psychology (www.infap3.eu), which has developed a database of studies conducted on analytical therapy across Europe (Roesler, 2018, 2020).

Like other psychodynamic approaches, analytic therapy has both immediate and long-term promise for mental health symptom reduction, positive personality construction, and client satisfaction with therapy (Roesler, 2020; Shedler, 2010). For example, Roesler (2013) noted the following in his review of empirical research:

> Jungian treatment moves patients from a level of severe symptoms to a level where one can speak of psychological health. These significant changes are reached by Jungian therapy with an average of 90 sessions, which makes Jungian psychotherapy an effective and cost-effective method. (p. 562)

Findings shared by the Societies of Analytical Psychology demonstrate that analytical therapy reduced symptom severity and interpersonal concerns, increased client well-being, and yielded high client satisfaction (Mattanza et al., 2006; Keller et al., 2002; Rubin & Powers, 2005; Tschuschke et al., 2010, 2015). Results across studies showed sustained results in three- to six-year follow-up studies, with additional evidence of personality reconstruction in ways that clients could address new and recurring problems.

It is important to note that long-term analytical therapy is supported in Europe and viewed as "cost effective," whereas in the United States, short-term counseling tends to range 5 to 25 sessions, so 90 sessions of "typical" analytical therapy would not be viewed as "cost-effective" (Roesler, 2013). Regardless, there is evidence that for a wide range of ailments, analytical therapy can be helpful if clients are committed to intense and relatively long-term therapy.

While research has suggested that analytical therapy can be effective, there is a strong need for further research within the United States and internationally. In particular, randomized controlled treatment studies (RCTs) that employ random assignment to multiple groups to evaluate treatment effectiveness is needed. Roesler (2020) notes several limitations of existing RCTs on analytical therapy, including quality control issues. Additional studies using quantitative and qualitative methodologies, along with meta-analyses and systematic reviews, should be conducted to build evidence of the efficacy of analytical therapy.

The Millers

The following shows Angela going through analytical therapy. After you read the vignette, answer the questions that follow. Refer to Chapter 1 if you need to review background information about the Millers.

Angela's Experience in Analytical Therapy

Angela plunged her hands in the deep, sudsy water; something about doing dishes by hand seemed to help her clear her mind. Lifting a cereal bowl from the bottom of the sink, her thoughts moved to family. "I feel like I'm falling apart," she said, glancing at her brother Markus, who was sitting at the breakfast table sipping his coffee. "I don't know if you noticed, but it seems like Jake is constantly on a verge of a panic attack, or he's so irritable that he's impossible to talk to."

"I guess I did notice he was on edge lately," Markus offered, "And what in the world is going on with the kids? How long has Luke been throwing things in the house?"

"I wish I knew. It's been going on for a couple of months. It's so embarrassing. I have the school calling about both kids—Luke's mouth and Celia's anxious stomach!" Angela said, moving the bowl to the drying rack. "Did you hear Jake asking me to home school Celia at breakfast again this morning? I feel so guilty. You know, if I had Celia home, she'd be doing better, but honestly, I think I'd go out of my skull at home all day."

"It's you I'm worried about," Markus offered frankly. "I haven't seen you this blue in a long time. Have you thought of maybe talking to someone? You could go see Dr. Bertram. She helped me a lot when I was trying to decide whether I should go back to school or not. I think you'd like her. She's a good sounding board."

Sitting down to meet with Dr. Bertram for the first time, Angela took in the blend of gray, tan, and beige of the office decor. The soft, steady sound of an air filter drew Angela's eye to a tank holding exotic fish. Floor-to-ceiling windows framed the view of a small park filled with flowerbeds and trees in full bloom. Dr. Bertram, a slender woman with sparkling hazel eyes, sat across from Angela and introduced herself, "I'm Dr. Bertram but, if you like, you can just call me Naomi. Please, tell me what has brought you."

Angela swallowed and began, "Well, Naomi, I'm just at my wits' end. It feels like my family is falling apart, and there doesn't seem to be anything I can do to stop it." Angela explained the difficulties that each of the family members had been experiencing and the tension that was building between them. "I'm really worried about all the arguing between me and Jake. We've never been through a time like this before. And I'm really uncomfortable with the way he picks at Luke. I don't think it helps. I really try every day to be the best wife and mom I can be, and still, things are a wreck."

Naomi glanced out the window for a moment and then seemed to settle more deeply into her chair, "It seems to me that you and Jake have different ways of looking at the world. Your empathy and your desire to understand how everyone is feeling—and to take care of them—is an important part of your character." Angela nodded as Naomi continued, "Jake's character is a bit different. From the way you describe him, he wants to take charge and return things to order. He seems less worried about the state of relationships and more concerned with making sure that Luke is behaving and Celia is less anxious. Would you say that is true?"

"Yes, that's a helpful way to describe this. Perhaps, we are just different in the way we look at problems and different in the way we would solve them. Different in our characters, to use your word," Angela conceded. "It helps, somehow, to understand the problem this way. Thank you for listening to me this morning; you really helped me get a new perspective on myself and on Jake, too. I feel some of the sadness I had coming in lifting a little. I had been feeling so inadequate as a wife and as a mom."

As the sessions with Angela unfolded, Dr. Bertram noted that Angela was developing a greater capacity to explore feelings and experiences she not been able to talk openly about even with her

brother, her closest confidant. In her time with Angela Dr. Bertram explored early experiences of caring for her sister. Angela described the embarrassment and inadequacy she felt as a child for not being a good enough caretaker for her little sister, Lillian. Angela has also begun to give voice to lingering shame about her sexual experiences during college.

"When I was in college, I always seemed to be taking care of men. My boyfriends always seemed to be guys who needed a lot from me and took a lot, too. Sometimes, they were abusive, and I just took it because I thought they needed me. To be honest, I felt like it was my job to make sure they felt good. I'm sure that's why I started having sex as early as I did. I wasn't ready." Angela sat quietly for a long time and then continued. "As I think back on it now, I think I was willing to do anything to make sure they would be okay. I didn't want to hurt their feelings, and it never occurred to me to think about my own needs or even what I wanted."

"And Jake? Was that how things were with Jake, too?" Naomi asked.

"No, not exactly. Jake seemed different. First, Jake did seem to care about me. He wasn't in a big rush to get me in bed like the other guys I dated. He could hold his own at the family dinner table conversations, where politics, religion, and race were always debated, and my family loved him for that. Those were great times. But now, he just seems to want to be in control. His anxiety has certainly gotten the best of him—and of me. He's trying to wedge me into the role of the 'caretaker' again. But I think I'm seeing that I have another part of me—a part that doesn't like people telling me what to do."

"You know, Angela, you aren't alone in all this. Lots of people get kind of caught up in one aspect or another of their character. Sometimes a particular trait gets amplified by life experiences and expectations," Naomi explained. "What happens is that a strong part of our character can begin to take over where it doesn't need to. We call it a 'complex.' All of us share models for how to be in the world, say as a man or a woman, a father or a mother, and these models are based on archetypes that have been around forever. Sometimes, when we have bad experiences that relate to that archetype, we develop a complex that ends up getting in the way."

"Maybe I have a 'caretaking complex,'" Angela offered. "I did have mixed experiences around caretaking when I was a kid. I took care of my little sister Lillian a lot when we were kids. I was proud of that, and I loved Lillian—still do—but sometimes my grandmother, and even my parents, were hard on me if I wanted to play with the other children or just wanted time to myself. My grandmother once told me I wasn't a good girl, that I was selfish, because I wanted to abandon Lillian, so I could play. I felt terrible; I hadn't even thought about how it would feel to Lillian if I went to play, and she had to stay home. But I was doing the best I could—I really was!"

"Angela, it feels very clear that you did your best to care for Lillian, even when there was a part of you longing to be free to play. You do the same now. You attend carefully to your family and their needs. The caretaking complex is still present for you. It leaves you with a lot of guilt for not homeschooling the kids or resolving Jake's anxiety for him. Yet there is a part of you that resists—part of you that longs to be free," Dr. Bertram noted.

Several months into therapy, Angela came into Dr. Bertram's office carrying a large canvas of heavy paper and placed it on the glass coffee table. Dr. Bertram leaned forward and examined the canvas. "This paper seems to be handmade. Did you make this?" she asked, noticing the delicate scattering of embedded leaves and petals within the paper's fibers. Angela smiled and nodded. Depicted on the canvas in pastel was the long, slender figure of a cocoa-skinned woman dressed in a silken cerulean gown. The woman was surrounded by countless children in hues ranging from creamy beige to a spectrum of browns. A male figure stood among the children. The woman towered over the children and the male figure. "I had a dream, Naomi, and when I woke up, I had to draw it. When I was in college I used to draw and paint and even made paper. I haven't had time to do that in years. This canvas is one I made before Jake and I were married. I used plants from my grandparents' home in Nigeria to dye the paper and to add texture."

"It is a captivating image, Angela! Tell me about the dream," Dr. Bertram invited, still examining the canvas.

"In my dream, I was married to Jake and we had adopted a dozen or more children. They were all different races—White, Black, and Asian. They seemed to be everywhere, and they were making a lot of noise. They were clamoring to be taken care of. Of course, they reminded me a little of my upbringing, with me being lighter skinned, my brother and sister being Black, my father being Nigerian, and my mom being White and American. Anyway, they were making all this noise, but I was very tall, and so the noise sounded like it was just in the distance. I was dressed in this silken gown—kind of sensual—you could see the trees and the grass and the sky reflected in it. Jake was much smaller than me but taller than the kids. I looked at him and said, with this deep, strong voice: 'Well, Jake, aren't you going to take care of the kids?' And, in the dream—I couldn't believe it—he said: 'Yes, of course I am.'"

"So, in this dream, it's kind of like a different you?" Dr. Bertram asked.

"I think this is another side of me; I was still very much a woman, but I was too big to care for the children and too big for Jake. But there was more, something I did not add to the canvas. In my dream there was another man. He wrapped his arms around me, and I knew we were getting married. He was built like a Roman god; he was a little terrifying, but when he looked in my eyes, I felt very excited."

"Dreams like the one you are describing often signal integration of parts of the self that have been cut off. Perhaps, you are embracing your shadow, the part of you that is terrifying, and your masculine energies, the animus. Does that sound right to you?" Dr. Bertram asked.

As the weeks passed, Dr. Bertram noted that Angela seemed to make strides in her Jungian analysis. Angela had grown stronger emotionally and had developed a curiosity and interest in uncovering new parts of herself during her sessions. Angela had become more comfortable exploring her fantasies and dreams in therapy and had been able to connect these two parts of herself that she had repressed. One morning Angela said, "Do you remember that drawing I brought in several months ago? I wonder if those children were really parts of me. I think that the voices of those aspects of myself were still far away when I had that dream, but they were wanting care and attention." As she continued in her therapy, Angela's artwork became more important to her. "Naomi, I cleared out a guest room at the rear of the house," she announced one morning. "Jake helped me move the furniture, and the kids helped me paint the walls. We transformed it into a small art studio. I never thought I would have a studio of my own, and now I do."

For You to Consider

1. Can you identify Angela's "psychological type"? What clues do you see in her behavior that suggest this type?
2. Can you identify Jake's "psychological type"? What behaviors suggest he might fit this type?
3. How often do you think differences in psychological type cause problems in relationships? Do you think that if two people have similar psychological types, they would be more likely to get along?
4. Reflecting on Angela's life experiences, what do you think contributed to the formation of her caretaking complex?
5. Reflecting on your understanding of Angela, what unexplored meanings are suggested in her dream? What most stands out for you?
6. How important do you feel dreams are in the therapeutic process? Do you anticipate using dreams in your own therapeutic work? Why, or why not?
7. Do you believe that all people share a persona, shadow, animus or anima, and a self? What evidence do you see that these exist? What about a personal unconscious and collective unconscious?

8. Jung often talked about the first half and second half of a person's life and said that in the second half, particular emphasis can be placed on understanding the personal unconscious and the collective unconscious. Psychologically, do you think Angela is in her first or second half of life?
9. Ultimately, where do you think therapy will take Angela? Do you think if she "grows" in therapy that she might ultimately grow away from Jake? What implications does this have for her and her family?
10. What is your guess about how long Angela would need to be in therapy?

Summary

This chapter began with a biography of Carl Jung, the developer of analytical therapy. Born in Switzerland, Jung's childhood was difficult, and his struggles early in life were fuel for his later theoretical formulations, including his ideas about universal symbols, archetypes, and the personal and collective unconscious. In Jung's early professional life, he was a psychoanalyst, but as he began to do his own research and examine Freud's theory more fully, he went in a different direction.

Jung believed that childhood influences affect our psychological makeup and that symptoms represent a desire to regain lost parts of the self—parts that have been repressed as a function of one's psychological makeup. By expanding our consciousness (revealing unconscious material to consciousness), the individual can integrate parts of the Self that have been pushed into the unconscious as well as primordial parts of the Self that have never been revealed to consciousness and become a more fully functioning "whole" person.

Jung stated that awareness of our conscious world develops soon after birth with the development of the ego and is a filter for how each of us uses the mental functions of sensation (sensing), thinking, feeling, and intuition. In addition to the mental functions, Jung suggested we are born favoring one of two attitudes: extraversion and introversion. The mental functions and attitudes make up what Jung called our character or personality. The ego, Jung believed, manages our mental functions and attitudes and allows continuity of our basic personality structure.

Splitting from many of his contemporaries, Jung suggested that the psyche consists of the conscious mind, which represents all of what we are aware; the personal unconscious, which represents repressed memories and experiences incongruent with our psychological type; and the collective unconscious, which houses our primordial images, called archetypes. Some of the more typical archetypes that Jung identified included the persona, the shadow, the anima and animus, and the Self. Jung also stated that certain complexes are formed in the personal unconscious and that these complexes obtain their energy from these and other archetypes. Jung stressed the importance of reclaiming and understanding all that is repressed if one is to be whole. He also noted that symbols in our life and the sometimes-mysterious synchronistic events that happen to us can be indicative of unconscious material important to our understanding of Self.

Jung was a prolific writer, although he never comprehensively described his theory in an orderly fashion. However, several techniques commonly used by Jungian analysts include employment of a dialectical process, use of active imagination, use of creative techniques, dream analysis, amplification, transference and countertransference, and interpretation. These techniques are all used to help the client get in touch with the unconscious to illuminate repressed parts of self, integrate those parts, and move toward completeness and wholeness, a process Jung called individuation.

Although there are criticisms of Jung and analytical therapy in terms of social, cultural, and spiritual considerations, there is great potential for this approach to be used for culturally responsive practice. For instance, Jung's notions about a collective unconscious and the universality of archetypes; the fact that all aspects of the person create the whole person; and the idea that we

should incorporate all aspects of Self and, thus, understand others more fully all suggest we have similar roots and are more alike than different. However, it was also noted that discrimination and racism, not highlighted in Jung's original theory, also impact a person, and psychotherapists should consider whether symptoms are more consistent with negative external factors or internal makeup. As perspectives on gender, spirituality, and other cultural constructs expand with an increasingly diverse clientele, counselors and psychotherapists can critique and revise aspects of analytical therapy. Expanding clients' contrasexual consciousness is one method for this in terms of gender affirmative and feminist counseling. Furthermore, Jung's ideas about God and religion have been seen as universal by some and a challenge to existing religions by others.

In reference to its efficacy the research on analytical therapy is very limited, partly due to the nature of the theory, which makes it difficult to directly evaluate Jungian concepts. Because it is a long-term therapeutic approach, it seems to embody many of the requirements that would make it an efficacious approach, such as the fact that there is a well-defined paradigm, the therapist can build a solid working alliance, the therapist is well-trained and can heighten client expectations that the approach will work, and the therapist knows how to implement their techniques. Available research does indicate immediate and long-term positive effects of the approach, including general symptom reduction, positive personality reconstruction, and client satisfaction with therapy. Additional RCTs and other studies would help show the effectiveness of analytic therapy.

Key Words and Terms

active imagination
alchemy
amplification
analytical psychology
anima
animus
archetypes
astrology
attitudes
character
collective unconscious
complex
conscious
consciousness
contrasexual consciousness
countertransference
creative techniques
dialectical method
dream analysis
ego
extraversion
feeling
Gnosticism
impersonal unconscious
individuation
inferior function
interpretation
introversion
intuiting
intuition
irrational functions
judging
mandala
mental functions
Myers–Briggs Type Indicator
perceiving
persona
personal unconscious
primary function
psyche
psychological types
rational functions
Self
sensation
sensing
shadow
symbols
synchronicity
tai-chi-tu
thinking
transference
wholeness
yin yang

Key Names

Bleuler, Eugen
Briggs, Katharine
Freud, Sigmund
Jung, Carl Gustav
Myers, Isabel Briggs
Rauschenbach, Emma
Spielrein, Sabina
Wolf, Toni

CREDITS

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Individual Psychology (Adlerian Therapy)

4

Learning Goals

At the conclusion of this chapter, readers will:

- be familiar with the life of Alfred Adler and the historical context in which he developed individual psychology
- have working knowledge of the contributions of Richard Dreikurs and Don Dinkmeyer,whose work with children influenced the popularity of individual psychology in the United States
- be able to articulate the Adlerian view of human nature, regarding how children's unique capabilities and personality traits are affected by early experiences and how memories of those experiences drive the individual toward his or her unique final goal
- understand how feelings of inferiority are related to one's striving for perfection, considering the holistic and teleological framework of Adlerian therapy
- have knowledge of key concepts of individual psychology, including uniqueness of the individual, feelings of inferiority, private logic, common sense, compensation, subjective final goal, style of life, striving for perfection, social interest, holism, schema of apperception, birth order, and courage
- be able to describe a wide range of therapeutic techniques often used with adults, including building a trusting relationship, encouragement, assessment, examining early recollections, exploring the family constellation, dream analysis, Socratic questioning and use of the dialectical method, teaching and interpretation, spitting in the client's soup, guided imagery exercises, role-playing and acting "as if," catching oneself, and task setting
- be able to describe a wide range of therapeutic techniques often used with children, including building a trusting relationship; encouragement; art, play, and creative therapies; limit setting; natural consequences; logical consequences; assessment; responding to identified behaviors; democratically held discussion groups; catching oneself; task setting; and commitment and practice
- understand the four phases of therapy and the techniques associated with them
- be able to identify important social, cultural, and spiritual issues, including how individual psychology lends itself toward a deeper understanding of the roots of oppression and how the Adlerian notion of God is used by individuals in their efforts to reach their goals
- have a working knowledge of current research available on the efficacy of Adlerian therapy

FIGURE 4.1 Michael Phelps

The fastest swimmer alive. "The greatest athlete of all time." "No one will ever outdo what he's done." These are the types of things that have been said about Michael Phelps, the winner of 23 Olympic gold medals. But it wasn't always that way. Earlier in his life, Michael was mocked by his peers for his large ears, told by teachers he would never amount to anything, and bullied at school for having attention-deficit/hyperactivity disorder (ADHD). But he overcame it all and, in fact, was driven to do well, partly because he felt inadequate. And now he's the "best ever."

So what do Michael Phelps and Alfred Adler, the developer of *individual psychology*, have in common? Like Phelps, Adler was driven by his own feelings of inferiority and based his theory on the importance that people place on overcoming their sense of inferiority. In this final chapter outlining psychodynamic approaches, we begin by presenting the background and achievements of *Alfred Adler*, who came to be one of the most talked about theorists of the last 100 years. Then, we discuss the Adlerian view of human nature; key concepts; important techniques when working with adults and children; the counseling process; social, cultural, and spiritual considerations; and efficacy research regarding the practice of individual psychology or Adlerian therapy. We conclude the chapter by applying Adlerian principles to Jake, a member of the Miller family.

Alfred Adler

> It is always easier to fight for one's principles than to live up to them. (Adler, 1939, as cited in Bottome, 1957, p. 64)

Born February 7, 1870, Alfred Adler was the second of seven children in a family of five boys and two girls (Furtmuller, 1964; Hoffman, 1994). The son of a Jewish grain merchant and, like Freud, Adler spent his early years in Vienna, Austria. Early in life, Adler struggled with rickets, a vitamin D deficiency, which causes softness of the bones and potential fractures. Finally recovering, he almost died at the age of five of pneumonia. The memories of these illnesses and how they affected him had a profound effect on his understanding of what motivates people.

FIGURE 4.2 Alfred Adler

Despite his illnesses, Adler was a popular and outgoing child, who did well in school but was not considered an outstanding student (Furtmuller, 1964; Watts, 2015a). Closer to his father than his mother, he would often try to outdo his "model" older brother, ironically named *Sigmund*, whom he believed his mother favored. And, perhaps not surprisingly, during his career, Adler would often be compared to his older colleague, *Sigmund Freud*. A natural interest in science, a need to achieve, and his early illnesses led him in the direction of medicine, and in 1895, he received his medical degree from the University of Vienna (Bottome, 1957; Selesnick, 1966).

Adler's young adulthood was spent in an Austria that was intrigued by Marxism yet saw the spreading of anti-Semitism. Although his parents were Jewish, Adler did not particularly relate to his cultural heritage. However, socialism was a "religion" of the time, and Adler had a philosophical interest in the aspect of socialism that stressed the importance of the common good. This common interest united Adler and his future wife, *Raissa Timofeyewna Epstein*. A strong woman and early feminist, she

came from Russia to study in Vienna. They married in 1897 and in 1898 had their first daughter, *Valentine* (*Vali*).

Although establishing himself initially as an ophthalmologist, Adler later went into general practice. Perhaps due to his sickly childhood, early in his career Adler developed an interest in how *feelings of inferiority* could be motivating. When treating circus performers who worked at the amusement park across from his office, this interest piqued when he realized that many of these athletically superior performers had compensated for weaknesses in body and mind. Soon, he began to reflect on how a person responds to the sense of inferiority that resulted from their physical conditions.

Adler's interest in the psychological effects of *organ inferiority* eventually turned him to psychiatry. Although Adler had already begun to develop his own theory, he soon found himself defending Freud's ideas, which were revolutionary at the time and being rebuked by the local intelligentsia (Furtmuller, 1964). Adler respected the elder Freud and believed that his ideas needed to be examined scientifically. This is probably why, despite his independent views on psychiatry, in 1902, Adler accepted an invitation by Freud to join an informal discussion group on psychoanalysis. Although a member of Freud's inner circle, Adler never really saw himself as a psychoanalyst and, instead, reveled in being an objective scientist who was interested in examining some of Freud's unique ideas (Ansbacher, 1962; Watts, 2015a). The same year that Adler joined Freud's inner circle, *Alexandra*, his second daughter, was born. Like her father, she too was to become a psychiatrist and, eventually, would have a major role in further explaining much of what Adler had written.

In 1905, Adler and his wife had their first son, *Kurt*, who would also follow in his father's footsteps and eventually extend some of his father's ideas. Also that year, Adler converted to Protestantism, although his conversion was more due to his sense that Judaism was too insular as well as the importance he placed on being part of a "group"—not to a belief in God (Bottome, 1957; Selesnick, 1966). In fact, Kurt Adler, in an interview late in his life, insists that he and his family were all atheists, although they believed in the importance of society's striving for many values represented in religion (Kaiser, 1995). In either case, religion did not seem to play a major role in Adler's life, except for how it affected personality development, particularly an individual's drive for wholeness and perfection (i.e., God being symbolic for the epitome of perfection; Adler, 1933/1964a; Bottome, 1957). During this time, Adler began to focus on how social issues can affect the person, publishing the article "Physician as Educator" (Adler, 1904/2002a).

Adler remained actively involved with Freud's psychoanalytic group, yet his thinking was often in stark contrast to Freud's. For example, he would quietly question some of the basic tenets of psychoanalysis, such as the sex drive being the underlying basis of our behaviors (Selesnick, 1966). In fact, Adler's thinking increasingly evolved toward the belief that individuals were predominately motivated by a desire to overcome feelings of inferiority by a *striving for wholeness* and a *striving for superiority*, which later was changed to a *striving for perfection*. This much more optimistic approach, as compared to Freud's deterministic and pessimistic theory, eventually led him to write one of his first books, called *A Study of Organ Inferiority and its Psychical Compensation* (Adler, 1907/2002b).

In 1909, Adler and his wife had their fourth child, Cornelia (*Nelly*), and soon after, in 1910, he became president of the Vienna Psychoanalytic Society, despite his increasingly different views from Freud's (Watts, 2015a). For Adler, his weekly meetings with the Society were an opportunity to examine and challenge some of Freud's ideas and to understand more fully what motivates people and personality formation. In stark contrast to Freud, Adler increasingly believed that education, politics, gender roles, poverty, and other social issues played a critical role in the development of the person.

With increasing tensions between Freud and Adler, he and several likeminded colleagues resigned from the Vienna Psychoanalytic Society, and in 1912, some of this group established the Society for Individual Psychology. The schism between the mild-mannered Adler and the indignant Freud

left Adler feeling embittered toward him for the rest of his life (Fiebert, 1997). Although respectful to Freud, Adler always insisted he was never a disciple or student of his and that his theory was developed independently from Freud's. Freud, on the other hand, "continued to heap abuse upon Adler for the 'heresy' of rejecting the tenets of psychoanalysis" (pp. 263–264).

Around the time Adler left the Psychoanalytic Society, he published *The Neurotic Character* (1912/2002c), which elucidated his views more clearly, and in 1914, he founded and became the first editor of the *Journal for Individual Psychology*. Drafted during World War I by the Austrian army to work as a physician, Adler saw the ravages of war after being sent to the Russian battlefront and, later, to a children's hospital. Considerably moved by these experiences, Adler became convinced that education could play an important role in eliminating war. As he developed his theory, he became particularly interested in how parents, teachers, analysts, and others could teach democratic values, impact social forces, and help people understand intrapersonal concepts that could aid in the healing of children and others (Adler, 1931/1992).

During the 1920s, Adler developed one of the first child guidance clinics (Bottome, 1957). Here, he offered workshops for teachers that focused on how social factors could impact children and, on a voluntary basis, consulted with teachers and parents regarding any child who was having difficulty in school. His clinics were generally housed in a school, and it was not long before Adler became well-known for his ability to work with children and their families. As one of the first to stress the importance of family members being present to fully understand the child, he is considered an important figure in the development of family therapy models (Goldenberg et al., 2016; Sherman, 1999). Adler was also one of the first to stress the importance psychoeducational groups could play in teaching people appropriate social behaviors, in helping the individual obtain feedback from others, and in gaining a sense of togetherness from others (Adler, 1931/1992; Buchheimer, 1959; Deutsch, 1958; Ricard, 2015).

Writings from a series of lectures he gave in Europe and the United States during his 50s and 60s revealed a person who was becoming increasingly holistic, future-oriented, humanistic, and socially focused (Carlson et al., 2006; Ricard, 2015). In 1926, he accepted a visiting professorship at Long Island College of Medicine, and in 1929, he became an adjunct professor at Columbia University. In 1930, he became honoris causa, or an honorary citizen of Vienna, for his achievements. Then, in 1932, despite his award, and even though he had converted to Protestantism, most of his clinics in Vienna were closed due to his Jewish heritage. This led him to leave Europe and take a full-time professorship at Long Island College.

Throughout much of his adult life, Adler fought all forms of oppression and tried to show how feelings of inferiority lead to abuse of power (Carlson et al., 2006; Watts, 2015a). In fact, Adler campaigned for women's rights and often spoke about injustice for people of color. Known as a peace activist, Adler was to personally suffer the ravages of war and abuse of power when his daughter, Vali, moved to Russia to escape the Nazis but was held captive by the Stalinist regime under false political charges. Missing her tremendously, in 1937, Adler wrote: "I cannot sleep and cannot eat. I do not know how much longer I can endure it" (Adler, 1937, as cited by Alexandra Adler in Manaster et al., 1977, p. 20). Days later, while on a lecture tour in Scotland, he died on the street of a heart attack. In 1942, Vali died under very harsh conditions in a Siberian prison camp.

Over his lifetime, Adler wrote more than 300 books and articles that tended to be more easily understood by laypeople than the writing of many of his contemporaries. Some of the more well-known books he wrote in his later years included *The Practice and Theory of Individual Psychology* (1925/1963a), *Understanding Human Nature* (1927), and *What Life Could Mean to You* (1931/1992).

Adler's influence over the years was widespread, with *Rudolf Dreikurs* (1897–1972) and *Don Dinkmeyer* (1924–2001) becoming particularly well-known for adapting individual psychology to their work with children. Like Adler, Dreikurs was an Austrian-born psychiatrist who immigrated to the United States. A student and colleague of Adler's, in 1952, he founded the Adler School of

Professional Psychology. Don Dinkmeyer, an American psychologist, met Rudolf Dreikurs in 1958. Impressed by Dreikurs, Dinkmeyer would spend the rest of his life developing Adlerian methods for children. Eventually, Dinkmeyer would develop training programs based on Adlerian principles, such as *Developing An Understanding of Self and Others (DUSO)*, which used hand puppets to facilitate communication with children and the *Systematic Training for Effective Parenting (STEP)* program.

Dinkmeyer and Dreikurs (1963) believed that children have an inherent desire to belong and to feel part of their peer groups (like Adler's concept of *social interest*) but, due to feelings of inferiority and poor parenting, some exhibit maladaptive behaviors in an unsuccessful attempt to gain this sense of belonging. Typical behaviors such children exhibit include *attention seeking* (e.g., interrupting), the *use of power* (e.g., bullying), *revenge seeking* (e.g., playing nasty practical jokes), and *displaying inadequacy*` (e.g., withdrawing). Dinkmeyer and Dreikurs believed that children can and must be taught new behaviors by significant others in their lives, such as parents, counselors, and teachers (Wolfgang, 2009). As a result of the influence of Adler, Dinkmeyer, Dreikurs, and others, individual psychology lives on with numerous associations and institutes around the world advocating this understanding of the development of the person (see Box 4.1).

BOX 4.1 Want to Meet Alfred Adler?

Want to hear a brief biography about Adler from the man himself and find other tidbits of information about him? Go to https://silver.odu.edu/psyadm/ to see a caricature of Adler talking about himself and his theory. Click on the psychodynamic door and go into Adler's office.

View of Human Nature

> Now the situations of individual children are extraordinarily different. In the one case we are dealing with an environment which is hostile to the child and which gives him the impression that the whole world is an enemy country. ... If his education does not forestall this fallacy, the soul of such a child may develop so that in later years he will act always as if the world really were an enemy country. (Adler, 1927, p. 35)

Adler believed that every child is born with unique capabilities and is inherently moving toward the future, not determined by the past. Using the word *teleology*, from the Greek teleos, meaning "goal-directed process," Adler suggested that we are driven toward the future to makes ourselves whole and complete and to fulfill our one true drive, our striving for superiority, later called our striving for perfection (Ricard, 2015). If unimpeded, this path would bring out our uniqueness and natural creativity, lead us toward connection and cooperation with others, and promote meaningfulness in life (Sweeney, 2019). All our drives, including our sexual or aggressive instincts, are subsumed by the drive for perfection, said Adler. Yet Adler warned that if one's striving for completeness, wholeness, and perfection was diverted by feelings of inferiority brought on by any number of reasons, including poor parenting, the individual would develop neurotic or even psychotic characteristics and behaviors. However, if afforded a corrective education by such people as teachers, parents, and a therapist, the child can change. And if the child can change, so too can the adult!

Part of being human, said Adler, was dealing with inevitable feelings of inferiority. In attempting to overcome those feelings, Adler believed that we all develop unconscious beliefs, or *private logic*. This private logic leads to what Adler originally called a *fictional final goal*, but which was later referred to as a *subjective final goal* or *guiding self-ideal* to emphasize the subjective nature of this phenomenon (Watts & Holden, 1994). Adler stated that the child's experiences by age five and their subsequent memories of those experiences were critical factors in the development of one's private logic and subjective final goal. He also asserted that the picture in one's mind of what

the individual would like to be, which was shaped by the subjective final goal, can drive a person throughout their life. Thus, Adler said, all behavior is goal-directed and purposeful and is related to the drive to attain the image held in our subjective final goal.

Adler suggested that our drive toward our subjective final goal, based on our private logic, can result in the development of behaviors that compensate for our feelings of inferiority (e.g., a "100-pound weakling" becomes an obsessed bodybuilder). Ultimately, we believe that our subjective final goal will bring us a sense of mastery, superiority, and—eventually—perfection, completion, and wholeness. For instance, Adler's feelings of inferiority over his ailments as a young child led him to develop a subjective final goal of conquering death, and thus, he was driven to become a doctor in this unconscious quest (Hoffman, 1994; Watts, 2015a). Michael Phelps developed his own private logic about what it meant to be bullied and compensated for these feelings of inferiority by putting his all into his natural ability at swimming. We can only imagine what his subjective final goal was, considering his performance at the Olympics (see Box 4.2).

BOX 4.2 Inferiority Leading to Superiority

Consider the star athlete who feels inferior at a young age but has talents to become superior in athletics. What private logic do you think they might develop that drives behavior toward superiority or perfection in athletics? What are the positives and negatives of being driven by such private logic? How might this person be different if their drive for perfection was not rooted in strong feelings of inferiority? Finally, consider what feelings of inferiority have impacted your private logic and how such logic drives you toward a desire for superiority or perfection. Is your striving for perfection helpful or a hindrance to you?

Box 4.2: Heinz L. Ansbacher and Rowena R. Ansbacher, "Basic Propositions of Individual Psychology," *The Individual Psychology of Alfred Adler: A Systematic Presentation in Selections from His Writings*, pp. 1-2. Copyright © 1964 by HarperCollins Publishers. Reprinted with permission.

Whereas private logic and subjective final goals of some lend themselves toward behaviors that enhance their natural abilities and characteristics, other private logic and subjective final goals lead toward maladaptive, neurotic, or even psychotic behaviors. Children free of mistreatment by others and children who have learned through healthy parenting how to effectively manage feelings of inferiority create a private logic in line with their natural abilities and characteristics and form a subjective final goal that eventually includes cooperation with others and social consciousness (Adler, 1932/1964b, 1933/1964c). In contrast, children who are abused and mistreated and do not learn how to manage their feelings of inferiority create a private logic that results in a subjective final goal that is manipulative, self-destructive, and/or disruptive of other people's lives. Consider the type of parenting, resulting private logic, and subjective final goal of children who become bullies or class clowns as compared to those who are social and cooperative members of the classroom. Finally, Adler suggested that the individual develops a *style of life* that is reflective of the person's movement toward their subjective final goal. Whether one's subjective final goal results in a lifestyle of healthy behaviors or maladaptive behaviors, the person's subjective final goal and its associated style of life is deeply rooted in the past, affects our present, and leads us toward our future (see Figure 4.3).

Some consider the roots of individual psychology to be embedded in the psychodynamic school because Adler believed in a conscious and unconscious and in the efficacy of in-depth counseling. In such work, the counselor helps the client understand how early experiences, and the memories of those experiences, have consciously and unconsciously led to private logic that affects the development of one's subjective final goal and is reflected in one's style of life. However, there are

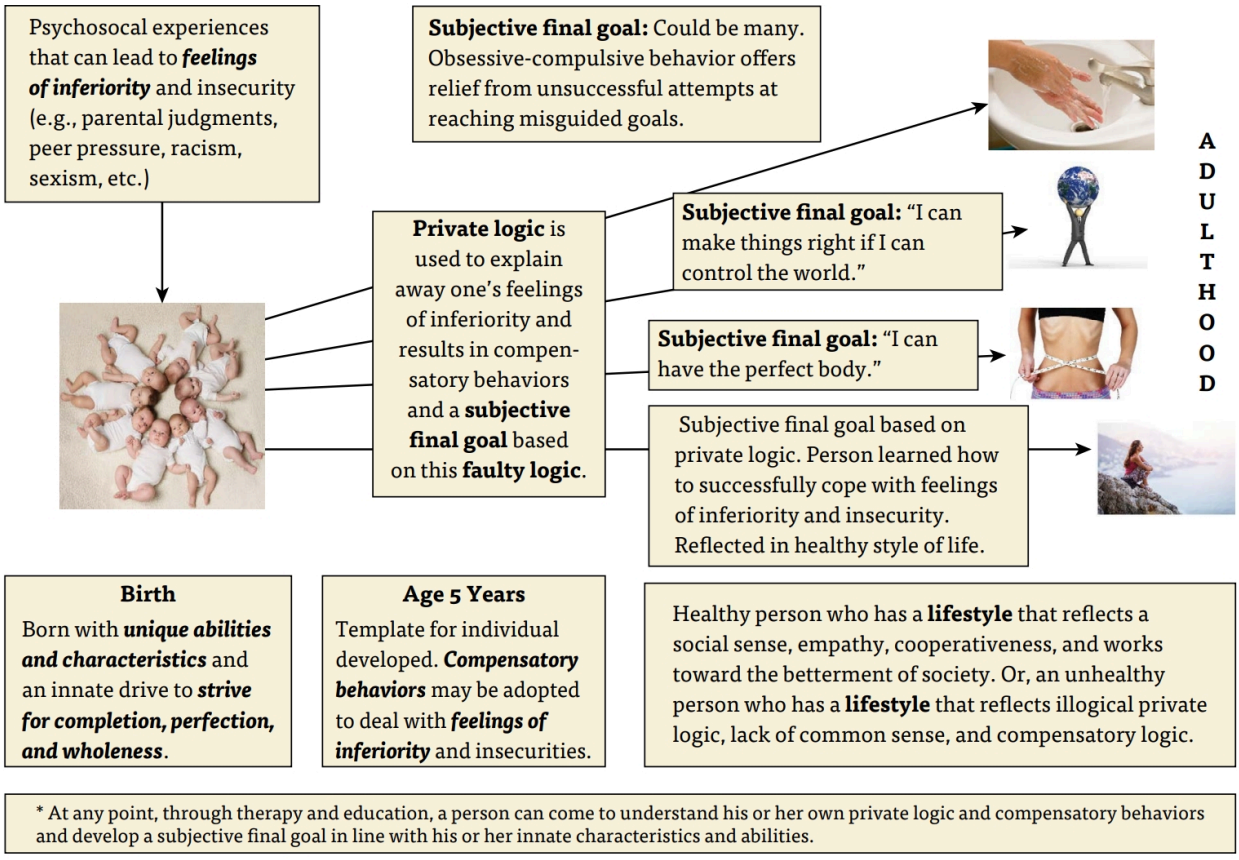

FIGURE 4.3 Relationship Between Feelings of Inferiority, Private Logic, Subjective Final Goal, and Lifestyle

also clear existential and humanistic leanings in Adler's approach (Stein, 2008; Watts, 2015a). For instance, Adler stressed the importance of *gemeinschaftsgefühl*, which loosely translates to "social interest." If unimpeded by feelings of inferiority, Adler believed that one would naturally move toward meaningful relationships, the best interest of others, the betterment of society, and an understanding of our place in the universe (Ansbacher & Ansbacher, 1956). Much like Maslow's self-actualized person, he believed in the individual's ability to become empathic, cooperative, social, and appreciative of the beauty of the world (Stein, 2008). Called one of the first humanists by some (Ansbacher, 1964), Adler believed people could change, and his theory is seen as an optimistic and *anti-deterministic* approach that impacted the development of many theories that fall into the existential–humanistic school.

Individual psychology has also been seen as a theory that has roots in the cognitive school of counseling because it highlights how we develop schemas (e.g., private logic) that impact our understanding of the world, which, in turn, impacts how we act in our lives (e.g., style of life; Adler, 1927; Watts, 2015a). In recent years, individual psychology has also been referred to as a social constructivist approach (Carlson et al., 2006; Mahoney, 2003; Watts & Shulman, 2003, 2015a). These individuals point to the fact that Adler was focused on the future (e.g., *teleology*), stressed the importance of social factors in the development of one's understanding of the world, and saw the individual as a person in process who is holistically "constructing" a new meaning-making system as they move through life. Finally, Adlerian therapy has been described as an approach that should be tailored to the client and, therefore, may be long-term or brief. Indeed, Adlerian counseling is often used as a brief treatment modality in schools as well as in clinical and agency settings

BOX 4.3 12 Propositions of Adlerian Therapy

1. **striving for perfection:** There is one basic dynamic force behind all human activity, a striving from a felt "minus" situation toward a "plus" situation, from a feeling of inferiority toward superiority, perfection, and totality.
2. **uniqueness of the individual; subjective final goal:** The striving receives its specific direction from an individually unique goal or self-ideal, which though influenced by biological and environmental factors, is ultimately the creation of the individual. Because it is an ideal, the goal is a fiction.
3. **unconscious:** The goal is only "dimly envisaged" by the individual, which means it is largely unknown and little understood by the individual. This is Adler's definition of the unconscious: the unknown part of the goal.
4. **teleology:** The goal becomes the final cause—the ultimate independent variable. To the extent that the goal provides the key for understanding the individual, it is a working hypothesis on the part of the psychologist.
5. **style of life:** All psychological processes form a self-consistent organization from the point of view of the goal, like a drama that is constructed from the beginning with the finale in view. This self-consistent personality structure is what Adler calls the style of life. It becomes firmly established at an early age, from which time on behavior that is apparently contradictory is only the adaptation of different means to the same end.
6. **holism:** All apparent psychological categories, such as different drives or the contrast between conscious and unconscious, are only aspects of a unified relational system and do not represent discrete entities and quantities.
7. **subjective final goal:** All objective determiners, such as biological factors and history, become relative to the goal idea; they do not function as direct causes but provide probabilities only. The individual uses all objective factors in accordance with their style of life.
8. **schema of apperceptions:** The individual's opinion of themself and the world, their "apperceptive schema," their interpretations, all as aspects of the style of life, influence every psychological process.
9. **social interest:** The individual cannot be considered apart from his social situation. "Individual psychology regards and examines the individual as socially embedded. We refuse to recognize and examine an isolated human being."
10. **social interest:** All important life problems, including certain drive satisfactions, become social problems. All values become social values.
11. **social interest:** The socialization of the individual is not achieved at the cost of repression but is afforded through an innate human ability, which, however, needs to be developed. It is this ability that Adler calls social feeling or social interest. Because the individual is embedded in a social situation, social interest becomes crucial for their adjustment.
12. **private logic:** Maladjustment is characterized by increased inferiority feelings, underdeveloped social interest, and an exaggerated uncooperative goal of personal superiority. Accordingly, problems are solved in a self-centered "private sense" (private logic) rather than a task-centered "common sense" fashion.

Note. Adapted from Ansbacher & Ansbacher, 1956, pp. 2–3. Words in parentheses are not in the original and are these authors' attempt at associating the proposition with a key concept that has been or will be discussed in this chapter.

(Dinkmeyer & Sperry, 2000; Fassino et al., 2008; Watts, 2013). Many of Adler's ideas concerning his view of human nature are summarized by Ansbacher and Ansbacher's (1956) 12 propositions, which can be found in Box 4.3.

Key Concepts

Some of the key concepts that underlie individual psychology include the uniqueness of the individual, feelings of inferiority, private logic, common sense, compensation, subjective final goal, style of life, striving for perfection, social interest, holism, schema of apperception, birth order, and courage.

Uniqueness of the Individual

From the perspective of individual psychology, each person is unique with innate abilities and personal characteristics that are impacted by early childhood experiences and the memories of those experiences (Adler, 1935/1964d). When interacting with others, feelings of inferiority are inevitable, and some will respond to these feelings by developing private logic and *compensatory behaviors* that lead to maladaptive, neurotic, and dysfunctional ways of living, while others will develop private logic and compensatory behaviors that support their unique abilities and characteristics. As you might imagine, those who develop behaviors that support their abilities and characteristics are more likely to be empathic and are more likely to develop and work toward a sense of harmony with self, community with others, and unity with all of humankind.

Feelings of Inferiority

> Every neurosis can be understood as an attempt to free oneself from a feeling of inferiority in order to gain a feeling of superiority. (Adler, 1925/1963a, p. 23)

Key to Adlerian therapy is the belief that each of us will inevitably experience feelings of inferiority (Stein & Edwards, 2002; Watts, 2015b). *Primary inferiority feelings* are universal, such as when infants and young children struggle with inherent physical, cognitive, and psychological hurdles of life (e.g., the 10 month old's attempt to walk or the toddler's attempt to comprehend basic knowledge; Stein, n.d.a). Such feelings can be overcome if children have supportive and encouraging parents and significant others. Ultimately, learning how to overcome such feelings in positive ways leads to healthy relationships, growth, and cooperation.

Feelings of inferiority can also be debilitating. Called *secondary inferiority feelings* (Stein, n.d.a), such feelings occur because of psychological struggles from poor parenting, child abuse and neglect, and cultural injustice (e.g., embedded racism in society). Such feelings can result in a person who retreats into self to avoid a sense of inferiority (e.g., becomes depressed and withdrawn), a person who tries to avoid feelings of inferiority by striving for superiority over others or other maladaptive behaviors. Secondary inferiority feelings lead to the development of faulty private logic and maladaptive compensatory behaviors as well as a subjective final goal that is narcissistic. By their very nature, secondary inferiority feelings will cause discomfort and strife among people (see Figure 4.3). Those who live by misguided beliefs (i.e., faulty private logic) believe that the attainment of their misguided subjective final goal will make them "whole." As an adult, an individual's level of neurosis is based on the degree to which secondary inferiority feelings have impacted the development of one's private logic, subjective final goal, and associated maladaptive compensatory behaviors.

Private Logic

> [N]o matter how wacky the child's actions may seem to an adult, they are logical to the child if it is recognized that his own picture of the world around him governs his reactions. So the trick is to find out how he sees the world, how this makes him do what he does, and help him to feel secure. (Armour, 1953, p. 63)

As the above quote implies, *private logic* is one's inner voice, self-talk, or internal images that justify one's style of life and fuels one's subjective final goal. It can result in healthy behaviors, movement toward one's inherent subjective final goal, and a desire to do good for the broader community. However, it can also result in compensatory (maladaptive) behaviors that divert the individual from his or her feelings of inferiority, prevent a person from moving toward their inherent subjective final goal, and not fuel the common good. Each person's private logic makes sense to them. However, when others view another person's neurotic compensatory behaviors, they may not understand the private logic that drives those behaviors. This is when the other person is seen as "different," "crazy," or "mentally ill," or given any of a host of diagnostic labels. If one were to truly listen to the inner world of the "different," "unusual," "crazy," or "mentally ill" person, one would find that it makes sense within that person's inner world. Understand a person's private logic, and you will understand their subjective final goal because that person's private logic is responsible for its development.

Common Sense

Common sense is those attitudes, beliefs, and behaviors that push us toward our inherent subjective final goal and result in the common good for the broader community. Those who have logical thinking and healthy behaviors use their common sense well, while those who are driven by their compensatory, maladaptive, behaviors are generally out of touch with their common sense. One goal of counseling is to help those who are unaware of their common sense to increasingly hear it, so they can slowly adapt their private logic toward behaviors that are congruent with their inherent subjective goal and the common good.

Compensation

> If a person is a show-off it is only because he feels inferior, because he does not feel strong enough to compete with others on the useful side of life. (Adler, 1929, p. 83)

Compensation is the act of consciously, or more usually unconsciously, covering up feelings of inferiority in one or more areas by taking on behaviors that drive a person in other areas. So the child who is made fun of due to his awkwardness becomes a superior runner, or the child who is harassed by her parents and told she will never make it in life becomes a straight-A student. Some types of compensation are healthier than others, as in the case of Michael Phelps, who became a gold medal swimmer partly due to being bullied. But many kinds of compensation can be harmful to the person and to society, such as the child who is beaten by their parents and becomes a bully in school and a sociopath as an adult. To some degree, all types of compensation lessen the person's ability to see their true self and reduce the likelihood that the individual will respond with common sense because all compensation involves covering up aspects of self that feel inferior and have low self-esteem (see Box 4.4).

BOX 4.4 Compensatory Behavior

When I (Neukrug) was a child, I was overweight and felt inferior about my looks. Later, as a young adult, I developed an obsession with working out. What might have been some of the positive and negative results of this compensatory behavior? How might my feelings of inferiority have impacted my private logic and lifestyle? Have you developed compensatory behaviors? How might they have impacted your private logic and lifestyle?

Subjective Final Goal

> You can traverse the country in a Volkswagen bus looking for "the answer," but you still have to bring yourself with you.

Arising out of one's private logic and compensatory behaviors, an individual's subjective final goal is the person's unique image of what they want to become to gain a sense of completion and wholeness. To understand one's subjective final goal, Adlerian therapists want to assess, "Toward where is this person moving?" Like the person driving the Volkswagen (VW) bus in the above quote, "the answer" is not found by looking at where the VW bus stops but where it is going because where it is going is based on the driver's image of where they want to be—the individual's subjective final goal.

Private logic that has been markedly affected by secondary inferiority feelings and resulting compensatory behaviors results in a subjective final goal that diverts the person away from the path in life they would have taken if such feelings had not existed. These individuals develop maladaptive, neurotic, and narcissistic behaviors that do not help themselves, the common good, the larger community, or society (Ansbacher & Ansbacher, 1956). Like in Figure 4.3, the woman seeking thinness, the greedy man seeking money at anyone's expense, or the despot seeking power, they have lost their way, but they're still in the driver's seat, thinking they are on the right path.

To uncover a subjective final goal, the Adlerian therapist must get to know the inner world of the client. By listening to the client's private logic, by examining compensatory behaviors, and by exploring early experiences, the counselor can understand the underlying insecurities and feelings of inferiority that led to the individual's subjective final goal.

> The child imagines sometime in the future when they will grow up, when they will be strong, when they will overcome insecurity or anything else that bothers them. So if they feel that they are ugly, they will be beautiful. If they feel that they're stupid, they will be brilliant. If they feel that they're weak, they'll be strong. If they're at the bottom, they'll be at the top. (Stein, 2000, as cited in Bridle & Edelstein, 2000, p. 128)

Style of Life

> The style of life of a tree is the individuality of a tree expressing itself and moulding itself in an environment. (Adler, 1929, p. 98)

As we strive to attain completion, wholeness, and perfection, we develop a unique repertoire of behaviors, cognitions, and values that Adler called our *style of life*. Each person's style of life is unique and reflective of how that person responded to early feelings of inferiority, the individual's private logic, the compensatory behaviors that were developed, and the individual's movement toward their subjective final goal. Our style of life (sometimes referred in this chapter as one's *lifestyle*) is

BOX 4.5 Understanding One's Style of Life

Using Stein's quote on p. 99 about the child who imagines their future, describe a possible style of life for the "ugly," "stupid," "weak," and "at the bottom" child as they develop as an adult. Compare your answers in small groups. Then, reflect on whether your style of life is at all based on feelings of inferiority.

represented in all our waking actions and is also reflected in our dreams. It can be seen in all of what we do, and it gives us hints about where we want to be (see Box 4.5).

Striving for Perfection

Adler originally posited that we are born with an inherent aggressive drive but later modified this as a striving for superiority and, lastly, as a striving for perfection (Adler, 1933/1964e). Despite its name change, the emphasis pretty much stayed the same: Adler believed that one's striving for perfection was the one innate motivating force of all people and posited that it is positive, pushes us toward reaching our subjective final goal, and lends direction toward our future as we strive for fulfillment, wholeness, and completion. Individuals who are not marred by secondary inferiority feelings will develop private logic and subjective final goals based on their innate abilities and characteristics and will exhibit qualities like individuals in Maslow's higher stages (e.g., the self-actualized person). For instance, this person is altruistic, empathic, loving, and has concern for family, community, and society foremost in mind (see Figure 4.3). In contrast, individuals who are affected by secondary inferiority feelings will develop misguided private logic, have poor common sense, and develop dysfunctional behaviors that result in subjective final goals that cause personal or psychological harm to self and to others (e.g., becoming anorexic or becoming a greedy, power-hungry politician; see Figure 4.3). Although still striving for perfection, these individuals have the misguided belief that if they obtain their subjective final goals, they will be fulfilled, whole, and complete. Unfortunately, their paths in life have been diverted by their responses to secondary inferiority feelings.

Social Interest

> We need the conscious preparation and advancement of a mighty social interest and the complete demolition of greed and power in the individual and in peoples. (Adler, 1928/1966, p. 171)

Derived from the German word *gemeinschaftsgefühl*, Adler believed that *social interest*, sometimes called community feeling, is an innate or evolutionary desire to relate to one another and build a sense of belonging and community with others. In its ideal form, it means a uniting of all humankind for eternity (Adler, 1933/1964e). However, Adler also believed there is a learned component to social interest and that the compensatory process that emerges from feelings of inferiority could prevent a person from developing their social interest fully. Thus, children who feel badly about themselves due to strong feelings of inferiority develop poor empathy skills and do not fully develop their social interest. These children become adults who compensate for their feelings of inferiority and develop subjective final goals that are not in the interest of the common good. Contrast this with children who have not been overly burdened by such feelings. These children become adults who build love and work relationships marked by empathy, caring, acceptance, and concern for the common good as they strive to reach their goals in life (Watts, 2007). Not unlike individuals who are self-actualized, such individuals have a sense of meaning in life, treasure the interconnectedness of relationships, work toward the betterment of society, are naturally esteemed by others, and feel valued and worthwhile. As you might imagine, one of the goals of therapy is to

help the client regain their natural social interest by helping them see how it has been thwarted by feelings of inferiority, misguided private logic, and compensatory behaviors.

Holism

In contrast to some other forms of psychodynamic therapy that see the individual composed of internal structures or forces that may, at times, conflict with one another (e.g., id, ego, and superego), the Adlerian views the individual as a holistic entity, attempting to move toward the completion of self and perfection. Even when such movement leads toward problematic behavior, Adler believed it is the individual's misguided attempt to strive for completion and perfection (Adler, 1929). Adler even viewed the conscious and the unconscious as working together toward a single goal, although the goal was sometimes not a healthy one, due to being deterred by faulty logic. In fact, the name "individual psychology" is actually a poor translation from Adler's actual title, *Individuum*, which in Latin means holistic or *holism* (Watts, 2015a).

Schemas of Apperception

Produced by our imaginations, our *schemas of apperception* are the cognitive rules (our *schema*) we have developed in our assimilation of our experiences (our apperception; Adler, 1927; Griffith & Powers, 2007). In other words, it is how we come to understand and make sense of the experiences in our lives. Developed within the first five years of life, schemas are based on our memories (and distortions of our memories) and will direct us away from our feelings of inferiority. For instance, rigid, dualistic, black-and-white thinking is often the result of a schema that views parts of the world as good and other parts as evil. Perhaps, our parents were sometimes abusive and sometimes loving; thus, we split them as we split the world—into good and bad. This cognitive rule (schema), therefore, places people in "camps"—the good camp and the bad camp. Such thinking is antithetical to the building of peaceful, loving relationships. Ultimately, our schemas impact the development of our private logic and are reflected in our style of life.

Birth Order

Realizing that *birth order* can greatly affect how one feels about oneself, Adler became one of the first theorists to focus on its importance. For instance, with firstborn children, parents are generally anxious about being good parents, are very concerned with how the child is growing and learning, are extremely focused on the needs of the child, and place more demands on this child compared to later-born children. Is it surprising that this child is often a high achiever and perfectionist? In a similar vein, second-born children experience not being the "first love" and are often attempting to catch up or dethrone the firstborn. And as you might expect, the middle child often feels "squeezed" and ends up being the "mediator" or "negotiator" of the family.

Based on knowledge like this, Adler and others began to identify typical behaviors of children that were a function of their birth order (see Figure 4.4). However, Adler and others were quick to point out that other factors could, and do, play an important role in how a person ultimately perceives themself. For instance, Leman (2015) suggests several characteristics that one might hold based on birth order but also acknowledges nine other factors that can mediate the development of the child (see Figure 4.4). For instance, under some circumstances, a secondborn child might have the experience of being a firstborn (e.g., a long-awaited male child is born and is given the attention the firstborn usually receives). Ultimately, birth order, other factors that impact a child's growth, and feelings of inferiority all play into the development of one's private logic, subjective final goal, and eventual style of life.

FIGURE 4.4 Effects of Birth Order Position

Courage

Most clients who initially come in for counseling find ways to avoid responsibility and tend to blame others for their problems. Their private logic has resulted in a subjective final goal that is reflected in a style of life that is harmful to themselves and others. *Courage*, for these individuals, means being willing to examine how early feelings of inferiority fueled their private logic, led to compensatory behaviors, and were partially responsible for the development of their subjective final goals. These individuals must develop the courage to face life's difficulties and take responsibility for change. In later stages of therapy, individuals show courage when they decide to actively work toward cooperation in their love and work relationships and when they demonstrate social interest.

Therapeutic Techniques

The following section addresses techniques applied with adults and separately explores techniques applied with children. However, there is overlap; many of the techniques used with adults can also be used with children, especially older children, and most of the techniques used with children can be applied to adults.

Techniques With Adults

Individual psychology relies on several techniques that encourage the client to become more aware of how early feelings of inferiority have been compensated for, as reflected in one's private logic, subjective final goal, and style of life. These techniques include building a trusting relationship, encouragement, teaching and interpretation, assessment, examining early recollections, exploring the family constellation, dream analysis, Socratic questioning and use of the dialectical method, spitting in the client's soup, guided imagery exercises, role-playing and acting "as if," catching oneself, and task setting.

Building a Trusting Relationship

Building a trusting relationship with the client, so they can feel free to examine feelings of inferiority, private logic, compensatory behaviors, subjective final goals, and a resulting dysfunctional style of life was critical to Adler. Often, this can be accomplished by using basic attending skills—most importantly, empathy. In addition, counselors build relationships by being respectful, cooperative, egalitarian, and optimistic. Finally, they are nonjudgmental, show unconditional positivity, and focus on strengths (Carlson et al., 2006; Watts, 2015b).

Encouragement

> According to psychiatrist Rudolf Dreikurs, humans need encouragement much as plants need water. He believed that every person with whom one comes in contact feels better or worse based on how others behave toward him or her. (Dinkmeyer & Eckstein, 1996, p. 17)

Used throughout the therapeutic relationship, from an Adlerian perspective, *encouragement* has to do with instilling courage and inspiring your client, being hopeful and confident, and believing in your client's self-worth (Wong, 2015). Watts (2015b) suggests that encouraging clients includes showing concern through active listening and empathy, highlighting client strengths and abilities, communicating confidence, identifying successes in life, focusing on client progress, affirming and appreciating clients, and helping clients see humor in their situations.

Near the beginning of the relationship, encouragement takes the form of showing clients you value them by providing empathy, being nonjudgmental, and showing acceptance. As clients begin to examine their lifestyles, they feel uplifted and encouraged by the counselor's support of their willingness to take an in-depth look at themselves. Clients are also encouraged later in the relationship when counselors acknowledge clients' willingness to make needed vital changes in their lives. Late in therapy, clients are encouraged, as counselors support their courageous efforts of working toward the common good and being cooperative with others in their love and work relationships.

Teaching and Interpretation

Throughout therapy, the counselor is *teaching* the client about the basics of the Adlerian approach. For instance, usually early on in therapy, the client is taught how feelings of inferiority may have affected personality development—specifically, the development of private logic, the subjective final goal, and one's style of life, although Adlerians differ on whether they identify these terms with their clients. In either case, the client is encouraged to examine how early recollections and placement in the family have affected current ways of living. When the therapist sees such parallels, and the client does not, the therapist may use *interpretation* and point out how current behavior reflects past recollections and feelings of inferiority that have been voiced by the client.

Assessment

Critical to understanding the client is conducting a thorough *assessment* of memories of early experiences, family relationships, work and love relationships, dreams and daydreams, and how the client has responded to important events and problems in their life. Conducted near the early phase of treatment, such an assessment helps the therapist understand how early feelings and experiences have led the client toward their current style of life and can provide clues concerning the client's subjective final goal. Assessments tend to be comprehensive and could include checklists, open-ended questions, and responses to specific structured questions (see Eckstein & Kern, 2002 for a sample of different assessment instruments). Areas that are generally focused upon in an assessment include the following:

- description of symptoms and presenting problems
- early memories and recollections
- how the client believes they would act differently if symptoms and problems did not exist
- the family constellation of the family of origin
- information about the family dynamics of the family of origin
- significant events in the client's life and the client's response to them
- current love relationships and how they might look if they were better
- current work relationships and how they might look if they were better
- current friendships and how they might look if they were better
- times when the client believes they have been treated poorly
- times when the client believes he or she has been discriminated against (or experienced discrimination)
- health issues and how the client responds to them
- use or abuse of substances
- addictions other than to drugs and alcohol
- physical well-being or lack thereof
- emotional well-being or lack thereof
- memorable dreams
- daydreams and fantasies

Examining Early Recollections

> In the style of life formed at the age of four or five we find the connection between remembrances of the past and actions of the present. (Adler, 1929, p. 118)

Early recollections are the screenplay that we use to develop our style of life (Adler, 1931/1958; Mosak, 2010). Because clients may distort their memories, early recollections may or may not be based on actual events. However, whether distorted or real, they provide a window to a client's early feelings of inferiority, help a therapist understand why a protective compensatory process may have been developed, and are the key to a client's private logic, subjective final goal, and style of life. Asking simple questions and encouraging clients to talk about early memories are basic skills therapists will use to both build the relationship and understand the client (Clark, 2002). Later in therapy, questions regarding early recollections can be used to prod the client toward understanding how they have developed faulty private logic that maintains a dysfunctional style of life. Some questions that might be used include the following:

- Can you tell me the first memory (or memories) you have?
- What do you think that memory tells you about yourself?

- What message about your life does that memory provide?
- Has that memory been a metaphor or reflective in some manner of how you have lived your life?
- How has that memory mimicked some feelings and behaviors you have had later in life?
- If you could change the memory, what would it look like?
- If the changed memory would, in some way, affect the rest of your life, how would your life look?

Exploring the Family Constellation

Like early memories, one's placement in the family offers a glimpse into the development of the individual. Being indicative of certain personality styles, one's *family constellation* can tell us a lot about a person, although mediating factors can also greatly affect one's childhood experiences (see Figure 4.4). The Adlerian therapist will often spend time collecting information about the family constellation as well as possible mediating events that impact the client's development (see Box 4.6). In fact, many Adlerians will bring families into the sessions to explore their interactions and to better understand how placement in the family affected the client's style of life (Starr, 1973; Sweeney, 2019).

BOX 4.6 The Effects of Birth Order and Idiosyncratic Issues

Being the middle child in a family with two parents, an older sister, and a younger brother certainly impacted my (Neukrug) life. Based on this information alone, you would expect me, the middle child, to be the mediator of the family, be even-tempered, try to outdo everyone, be the problem child, and so forth (see Figure 4.4). And indeed, I do have some of those qualities. However, between the birth of my sister and myself, my mother had a miscarriage late in her pregnancy. Also, I was overweight and sick with a heart disorder as a child, and due to these issues, my parents tended to pamper me. Also, because I was five years apart from my sister and brother, the "usual" qualities of the middle child don't always hold. In some ways, I was treated like a firstborn, and in other ways, like an only child. In either case, what goes into becoming a person is often complicated, and you can see that many factors need to be considered when examining one's family constellation. What factors have impacted you within your family constellation?

Dream Analysis

> A dream is always a part of the style of life and we always find the prototype involved in it. (Adler, 1929, p. 155)

In contrast to Freud who interpreted dreams as often having sexual and aggressive underpinnings, the Adlerian perspective views dreams as representative or metaphoric of a client's current style of life. Thus, *dream analysis* is often focused on understanding one's current style of life and, as therapy continues, bringing up possibilities for the development of a more fulfilling lifestyle that includes greater social interest. This is why Adler stated that dreams were forward-looking and had problem-solving functions (Adler, 1929; Ansbacher & Ansbacher, 1956). As with psychoanalysis, Adler believed that dreams had *manifest meanings* (obvious; on the surface) and *latent meanings* (hidden) and that it was important to point out, or interpret to the client, how a dream could be a vehicle to help the client take a new and more courageous and meaningful path in life.

Socratic Questioning and Use of the Dialectical Method

A centerpiece of Adlerian therapy is the building of an equal relationship in which there is a give and take between the client and therapist (a "dialectic"). The aim of this *dialectical method* is to encourage the client to seek the underlying reasons why their style of life has been developed. In this process, questions and gentle prodding, sometimes called *Socratic questioning*, are used to dislodge the self-indulgent, narcissistic, and noncooperative tendencies that many clients have developed as a reaction to their early feelings of inferiority. In essence, clients are shown that their current style of life is not working for them and given reasons why this is the case. Questions such as, "Is this working for you?" "Do you think that is the most effective way of acting?" or "What might be some other ways you could have responded?" can all be used to gently challenge the client to examine their style of life. As the client accepts the possibility that their current style of life is not effective, they are gently prodded toward developing a new style of life that is highlighted by increased empathy, cooperation, and social interest.

Spitting in the Client's Soup

In their own inimitable ways, clients have crafted styles of life that seem correct but, in actuality, have been preventing them from reaching higher goals—ones that embrace empathic, loving, and cooperative relationships. Clients can become so stuck in their current ways of acting that they become unable to see the reality of their styles of life. In these cases, counselors can use a variety of responses as they *spit in the client's soup*, or show them that their current ways of functioning are not healthy. For instance, satire can be used, such as in the following therapist–client dialogue:

> Client: Well, you know, I really feel like I deserve more respect from my wife. I work hard, earn lots, and I feel like she doesn't even give me the time of day. All she does is take care of the house, and now that the kids are older, she doesn't even have that responsibility. She just lives off of my money. She needs to listen to me more and respect what I say.
>
> Counselor: Well, I guess you are the king of this house! She should just listen to your every wish. Why, you shouldn't have to make any effort at having a dialogue with her—should you?

Guided Imagery Exercises

As clients become increasingly aware of their styles of life and prepare to change the way they are living, they can begin the process by imagining new ways of being. Counselors can help clients do this by providing *guided imagery exercises* in which clients mentally imagine new ways of acting and being with loved ones, in work relationships, and in social situations. Such guided imagery is often the first step, prior to trying out new behaviors.

Role-Playing and Acting "As If" (Fake It Till You Make It)

Realizing they could have a different and more highly functioning style of life, clients can begin to toy with the idea of what that life might look like by *role-playing and acting "as if"* their life was different. With the therapist's help, clients can first reflect on, and later role-play, new desired behaviors (Watts, 2015b). When comfortable, the client can begin to act as if they are that new person. The therapist can encourage these new behaviors and can act as a "coach," as the client

attempts to practice new, healthier ways of living. Groups in which trust has been built can often be the first place a client can practice a new behavior and receive feedback about its effectiveness.

Catching Oneself

As clients become increasingly aware of their behaviors that are driven by their private logic and subjective final goals, counselors can suggest that they try to "catch" these behaviors prior to their happening (Watts, 2015b). *Catching oneself* often starts with listening to one's inner voice and being mindful that the behavior is about to occur, which, at first, can be difficult. However, with practice, clients will be able to identify their thoughts, understand their private logic, and see the relationship between their private logic and their behaviors (see Box 4.7).

BOX 4.7 Children Can "Catch Themselves" Too

"Catching oneself" is not just a technique for adults. A funny but poignant example is from my (Neukrug) daughters when they were nine and 14 years old. Their mother, Kristina, noticed that our nine year old, when having a disagreement with her 14-year-old sister, would say things to her like, "You are always mean to me" and sometimes follow up with an attempt to hit her. Kristina suggested to my nine year old that she "catch" the word "always" and change it to "sometimes," and, of course, not hit her sister. This was a more realistic response, as most of the time the girls actually got along. It would also help to create a more ongoing caring relationship, as the two would be less likely to dig into their different "camps" that suggested each were "evil." I watched our younger daughter practice this change. At first, she would blurt out: "You always—sometimes—are really nasty to me." Over time, however, she was able to move to a more consistent statement of: "You sometimes are really nasty to me," and this would not be followed up by an attempt to hit her. This was a small but significant change.

Task Setting

Tasks are used to help clients develop a new style of life that is more compatible with their unique personality style (Dinkmeyer & Sperry, 2000). After gaining insight about their styles of life and deciding to make changes, *task setting* begins as clients identify new ways of being and develop specific steps they can take in the change process. Tasks should be client initiated, although they can be counselor enhanced. In addition, they should be time limited, so clients do not feel they will have to struggle with the task for life. Finally, they should be attainable, measurable, and realistic, so clients and counselors can discuss progress made toward the task during each session.

Techniques With Children

Adlerian principles have been adopted for use with children more frequently than other therapies. This is largely because of the following:

- Adler believed that feelings of inferiority from childhood are the main causes for maladaptive behavior. Prevent early feelings of inferiority, and you prevent maladaptive behaviors.
- There is no clear separation between the unconscious and conscious; thus, one can work directly with children's current knowledge base and not have to "break through" to some mysterious unconscious drives or beliefs.

- Adlerian therapy is optimistic and anti-deterministic, and change can occur (or start) at any point in a person's life.
- Since education and interventions are seen by Adlerians as possible and important, parents, teachers, and therapists can all work with children to affect change.
- Adlerian principles can be easily understood, thus making them easy to use by laypersons and by children.

The following offers a brief overview of a few of the major techniques for use with children and includes building a trusting relationship; encouragement; art, play, and creative therapies; limit-setting; natural consequences; logical consequences; assessment; responding to identified behaviors; democratically held discussion groups; catching oneself; task setting; and commitment and practice.

Building a Trusting Relationship

As with adults, *building a trusting relationship* with the child is crucial if you are going to garner accurate information from the child and be able to execute effective interventions (Kottman & Meany-Walen, 2016). Counselors should be good relationship builders by using attending and empathy skills, being nonjudgmental, being optimistic, focusing on strengths, asking questions in a nonthreatening manner, and fostering open discussion. In addition, they should be willing to "get on the floor" with children and do play activities, use art, and conduct play and creative therapies. These skills demonstrate interest toward the child, are ways of eliciting information from the child, and can be mechanisms for offering feedback to the child.

Encouragement

Those in positions of authority over children, such as parents, teachers, and therapists, play vital roles in the development of a child's sense of well-being and feelings of being worthwhile. One way these individuals can assist children in developing a positive sense of self is by exhibiting behaviors that encourage children. *Encouragement* by a significant person helps the child feel uplifted and fosters the child's willingness to change behaviors. Dinkmeyer and Dreikurs (1963) suggested four ways that encouragement is shown: (a) valuing and accepting the child, (b) using words that build a child's sense of self, (c) believing in the child, and (d) planning experiences that ensure success.

Art, Play, and Creative Therapies

> In Adlerian play therapy, your job is to observe the child in the playroom, understand how the child's lifestyle and life situation are presented through play, and begin to articulate that understanding to the child. (Kottman & Meany-Walen, 2016, p. 3)

Art, play, and creative therapies can be used to develop a trusting, safe relationship with children and to uncover the style of life that the child has adopted (Kottman & Meany-Walen, 2016; Landreth, 2012). Because art, play, and creative therapies minimally use verbal responses, they are often more amenable to children, especially younger ones. As the child draws or responds to objects, whether they are paintings, clay, dolls, or other objects, the child is exhibiting their style of life. For instance, an insecure child might draw a picture of themself at a distance from the other children in their class, as they hold on tightly to a doll, symbolizing their fragility and separateness from the group. In contrast, an aggressive child might choose soldier figurines and actively have them fight with one another. Ultimately, the goal of Adlerian play therapy is to help children learn new

attitudes and behaviors that can replace former, self-defeating ones that were based on the child's dysfunctional style of life.

Limit Setting

As children exhibit behaviors nonconducive to healthy functioning, *limit setting* will sometimes be used to change the child's behaviors (Kottman & Meany-Walen, 2016). While keeping in mind that the child is exhibiting these negative behaviors to continue their current style of life, limit setting involves the development of a set of rules established by the therapist (e.g., no hitting during a session). The therapist should encourage the child not to break limits while gently prodding the child toward new, healthier behaviors. If the rules continue to be broken, despite encouragement on the part of the therapist, then natural or logical consequences should be employed.

Natural Consequences

Perhaps best explained as "letting nature take its course," *natural consequences* come about after letting the results of an ill-advised behavior happen (Ferguson, 2009). For instance, a child who loses track of time because he's talking to friends misses getting to his favorite gym class on time. The door has been locked, and he is not allowed in. Or the child who insists on not taking an umbrella gets rained on.

Logical Consequences

Like natural consequences, *logical consequences* come about via the intervention by another person, usually one who is in a position of authority, who places a "logical" or "commonsense" consequence to a behavior (Ferguson, 2009). So the child who talks excessively during class is asked by the teacher to leave, so they won't distract others. Later, the teacher asks this child to make up the work during recess, when the student can't distract others. Or the child who acts aggressively toward the counselor loses "play time" with the toys in the counselor's office.

Assessment

As noted earlier, Dinkmeyer and Dreikurs (1963) identified four types of dysfunctional behavior in children: *attention-seeking, the use of power, revenge-seeking,* and *displaying inadequacy.* It is important for the counselor to identify a child's general style of behaving to assess their developing style of life and to match appropriate interventions to types of behaviors exhibited. As you might imagine, a child who is bullying (power-hungry) needs different kinds of interventions than one who is withdrawing (displaying inadequacy). Assessment can be conducted by asking a child to draw their place in the family and by drawing significant events in the child's life; by talking with and asking questions of the child in an attempt to try to assess the child's primary mode of acting; by observing the child in the home, classroom, and other important places in the child's life; and by asking others, such as teachers and parents, about the ways they see the child behaving. Children and significant adults can also be queried about birth order and significant events in the child's life.

Responding to Identified Behaviors

Once behaviors are identified, interventions can be applied. For instance, in *responding to identified behaviors*, Albert (2003) offers some examples of ways to respond to the four maladaptive behaviors noted earlier. For instance, to a child who repeatedly makes themself the center of attention, one

could ignore the behavior; give an "I message" (e.g., "I'm disappointed that you don't want to help out more."); make a lesson out of the behavior; do the unexpected, such as turning out the lights or talking to the wall; lower one's voice; distract the child by asking a direct question or by changing the activity; or move the child to a "thinking chair."

Democratically Held Discussion Groups

Children who exhibit maladaptive behaviors in the classroom, or in the family, have generally not been exposed to discussions based on democratic principles. Counselors, teachers, and parents can lead *democratically held discussion groups* by ensuring that all individuals are given an opportunity to talk, that all individuals are heard, and that basic principles like consensus taking or voting are applied when making decisions (Alvy, 1994). Providing an atmosphere of acceptance while offering the structure that allows children to make decisions in a fair-minded way can help them develop increased social sensitivity and dissolve some of their past ineffective ways of behaving.

Catching Oneself

The same technique as described in the adult section, *catching oneself* has to do with children learning how to "catch" thoughts and behaviors that are incompatible with a healthy style of life (Watts, 2015b). Children are often not given credit for their ability to have insight and catch behaviors. However, they are often able understand more than is generally acknowledged. As with adults, children can be taught how to catch their thoughts and behaviors and begin to make change (see Box 4.7).

Task Setting

As with "catching oneself," *task setting* is a technique that can be applied to adults or to children. With children, counselors may be more proactive in suggesting tasks be completed, although such tasks should resonate with the desired change in the child's style of life. As with adults, such tasks should be time limited, attainable, measurable, and realistic, so clients and counselors can discuss progress made toward the task during each session.

Commitment and Practice

Counselors show commitment when they consistently model healthy behaviors, encourage children regardless of the behaviors they exhibit, are dedicated to children and the change process, and never give up on a child. Such counselors give children the message that they believe they can change and they can take on responsible and socially minded behaviors in the change process (Adler, 1930/1963b). Change is not easy, and children will need someone in their corner cheering them on in the change process as the child tries on new behaviors. *Commitment and practice* take dedication and encouragement on the part of the counselor and an attitude that the counselor is there for the child, no matter how long the change process takes.

The Counseling Process

For children and adults, the purpose of the therapeutic relationship in individual psychology is to help clients gain insight into how their current style of life (i.e., lifestyle) is not working for them and develop new behaviors that will lead to healthier relationships highlighted by empathy, a sense of belonging, and cooperation (Carlson et al., 2006). Adlerian therapy can be viewed through a

series of four phases, which include *building the therapeutic relationship, assessing and understanding the lifestyle, insight and interpretation,* and *reeducation and reorientation* (Kottman & Meany-Walen, 2016; Watts, 2015b). The client who experiences these phases will most likely find a therapist who is more collegial, friendly, briefer, and more action oriented than most other kinds of psychodynamic therapists (Carlson et al., 2006). Table 4.1 cross-references the phases with the skills most likely associated with each phase, although the Adlerian therapist feels free to use some of these techniques or other techniques at varying phases if it will facilitate client growth.

Building a Trusting Relationship

As in most therapeutic relationships, this first phase of therapy involves the development of a trusting relationship. The Adlerian therapist does this by using the relationship-building skills identified earlier as well as encouraging the client for their willingness to begin the therapeutic journey. Although some of the skills vary based on whether one is working with a child or an adult, the purpose is the same: to build a relationship so one can begin the process of understanding the client's style of life.

Assessing and Understanding the Lifestyle

With knowledge that the client's values and behaviors are based on the client's unique schemas of apperception and resulting private logic, a thorough assessment is conducted to begin to uncover relevant information about the client's feelings of inferiority, misguided private logic, and compensatory behaviors and to better understand the resulting lifestyle. Assessment for younger children involves using art, play, and creative therapies as well as applying some traditional assessment techniques (e.g., interviews with the children and others). For adolescents and adults, traditional assessment techniques, examining early recollections, exploration of the family constellation, dream analysis, and more are used to help understand the adult's private logic and style of life.

Insight and Interpretation

A thorough assessment can help clients and counselors become insightful regarding the reasons the client has developed a certain style of life. With younger children, who have not fully developed the capacity for insight at deep levels, the counselor can be the vehicle for devising techniques based on their interpretation of the child's style of life. With children in particular, it is important to recognize that, although insight often precedes change, it is not a prerequisite for change. With adults, insight can come in many ways, and there are a wide range of techniques that can help foster such knowledge. Whether it is the counselor who has now developed insight into the young child's behaviors or the older client and counselor who have jointly begun to understand the client's unique lifestyle, the stage is now set for the next phase of therapy: reeducation and reorientation.

Reeducation and Reorientation

The goal of this last phase of therapy is to have the client adopt a new style of life based on the insight that has been gained about the client's current lifestyle. Here, either the therapist devises a plan for change (as in the case of a young child), or the older client, in consultation with the therapist, jointly discusses ways in which the client can change. Activities chosen at this phase can be practiced during or outside of sessions and are selected to develop and embed a new lifestyle more congruent with the client's unique personality and driven by a subjective final goal that is not built on misguided private logic.

As the client continues in this phase, they increasingly experiment with new behaviors and new values, and the therapist gently encourages the client to let go of unproductive patterns, while reinforcing and affirming the new, healthier patterns that include cooperation and the valuing of others. Increasingly, the client realizes the struggles inherent in living and the courage needed to make changes that will lead to cooperation and empathy toward others. At this point, therapy may end, although some clients may continue in what Stein and Edwards (1998) call the *meta-therapy phase*, wherein clients examine the nature and meaning of life.

TABLE 4.1. Phases and Commonly Used Techniques in Adlerian Therapy

	Techniques Commonly Used With Children	Techniques Commonly Used With Adults
Phase I: Building the Therapeutic Relationship	• building a trusting relationship • art, play, and creative therapies • limit setting • applying natural consequences • applying logical consequences • encouragement	• building a trusting relationship • encouragement • teaching and interpretation
Phase II: Assessing and Understanding the Lifestyle	• building a trusting relationship • art, play, and creative therapies • assessment • limit setting • applying natural consequences • applying logical consequences • encouragement	• building a trusting relationship • assessment • examining early recollections • exploring the family constellation • dream analysis • teaching and interpretation • encouragement
Phase III: Insight and Interpretation	• building a trusting relationship • art, play, and creative therapies • democratically help discussion groups • encouragement • responding to identified behaviors • limit setting • applying natural consequences • applying logical consequences	• dream analysis • examining early recollections • exploring the family constellation • Socratic questioning and the use of the dialectical method • teaching and interpretation • spitting in the client's soup • encouragement
Phase IV: Reeducation and Reorientation	• responding to identified behaviors • limit setting • applying natural consequences • applying logical consequences • democratically held discussion groups • catching oneself • task setting • commitment and practice • encouragement	• Socratic questioning and use of the dialectical method • guided imagery exercises • role-playing and acting "as if" • catching oneself • task setting • commitment and practice

Social, Cultural, and Spiritual Issues

> [Adler] created his own complete psychology which explicitly valued social justice. Adler is a stellar example of a professional who successfully embraced and advanced both the micro and macro world of mental health. ... Adler spoke out vehemently against the marginalization of minority groups, campaigned for women's social equality and predicted both the Women's liberation and Black Power movements. (McCluskey, 2021, pp. 2–3)

As we have described throughout this chapter, Adlerian therapy is a holistic, contextual, action-oriented, socially embedded, and goal-driven approach with an emphasis on client strengths, encouragement, optimism, empowerment, advocacy, and support. As such, Adler, and other theorists of individual psychology, view clients as socially motivated, socially constructed, and capable of creative independence. Furthermore, therapeutic progress is accomplished through understanding the subjective experience of each individual and the unique interpretation of oneself and others by fostering a trusting and egalitarian relationship that can build a bridge between cross-cultural differences. Thus, Adlerian therapy aligns well with culturally responsive practice (McCluskey, 2021).

> The striving for personal power is a disastrous delusion and poisons man's living together. Whoever desires the human community must renounce the striving for power over others. (Adler, 1928/1966, p. 169)

Adler saw how power is misused by parents, in relationships, by men over women, by culture over culture, and by one country over another. For instance, he believed that the desire for power and the loss of social interest and social concern could be seen in men's subjugation of women:

> The subjugation of women came with the invention of war and the consequent rise in the importance attached to physical strength and endurance. The resulting mass attitude and movement was decidedly unfavorable to women. ... The conflict resulting from the attempt to subjugate women has played great havoc both in private and social life. (Adler, 1937, p. 117)

In a similar vein, Adler saw the desire for power and superiority as being the major causes of struggles and the oppression of minorities:

> Those who have traveled have found that people everywhere are approximately the same in that they are always inclined to find something by which to degrade others. ... Until mankind consents to take a step forward in its degree of civilization, these hostile trends [prejudices] must be considered not as specific manifestations, but as the expression of a general and erroneous human attitude. (Adler [1925, 1930, 1934], summarized by Ansbacher and Ansbacher, 1956, p. 452)

Adler interpreted how clients moved through the world by accepting or rejecting values of the family and the larger culture as a way for them to gain significance. As an example, masculine behavior is inferred by what society values. He noted that children perceived society favoring the superiority of males as an example of one value unknowingly modeled to children (Johnson-Migalski et al., 2020). Furthermore, Adler (1929/2005) surmised the impact of culture and gender on peoples' self-concepts:

> A girl's feeling of inferiority may be markedly increased when she realizes that she is a female, and a boy's also when he doubts his maleness. Both compensate by an exaggeration of what they imagine to be masculine behavior. (p. 28)

As you might guess, Adler believed that the desire for power, which is always rooted in feelings of inferiority, resulted in the loss of social consciousness (Adler, 1928/1966). However, he believed that people could understand that the very oppression they have experienced was the root of their feelings of inferiority and that those same feelings are the cause for a cycle of oppression—those who are oppressed often become the oppressors. And he believed that through counseling and education, there could be an enlightenment that would, ultimately, allow individuals to work together for the common good—to have social interest.

In practical terms, to be an Adlerian means that you understand the roots of oppression, and you want to do something about it. You can change others, and change the world, by being a counselor, by being an educator, and by advocating for political change. Being an Adlerian means that you understand the importance of a social conscience and that you have no choice but to advocate for the betterment of all. Adler was careful not to pathologize people, and he viewed neurosis and psychosis as evidence of clients having difficulty coping with life because they had become deeply discouraged (McCluskey, 2021).

Johnson-Migalski et al. (2020) proposed several cultural considerations in individual interviews, based on Adlerian constructs to facilitate the integration of clients' social and cultural contexts. They are as follows:

- client and parent values and degree of alignment across them,
- what personality traits parents model to their children,
- cultures represented in the family, including gender expectations and roles, and
- feelings of inferiority within the family and society related to physical expectations, gender roles, sexual orientation, etc.

When interpreting interview data, Johnson-Magalski et al. suggested that counselors should consider the following:

- Was the emotional tone and transactional way of operating influenced by culture?
- What was the structure of this family, or how did this person experience the structure?
- What were the social contingencies and/or cultural factors or values that influenced this structure?
- What were the social contingencies and/or cultural factors that influenced this person's response?
- How did the person respond to the structure, climate or emotional tone, and interpersonal transactions?

Turning to religion, how might an Adlerian work with a religious person? As you have seen, to say Adler was not a religious man would be an understatement, yet Adler understood the nature and importance of religion. He believed that God symbolized perfection and that the values inherent in this image, embraced by religions, are ones that we all should strive for. Religion, therefore, helps us define the values for which we should strive—values that, for the most part, stress equality, cooperation, and love, which are many of the same values highlighted in Adlerian therapy (Watts, 2000, 2007). However, religion can also be dogmatic and abusive and can be a cause for feelings of inferiority. Such religious dogma would not be supported by an Adlerian. In the end, religion can be embraced when it helps people strive toward God-like values but should be rebuked when it is abusive and oppressive:

> You can use every religion for good and for bad because religion can be used to elevate a person or it can make him a failure, for unfortunately all the best ideas can be abused. (Adler,1935, as cited in Stein, n.d.b, para. 5)

Efficacy of Adlerian Therapy

> Dynamically oriented psychotherapy has only infrequently been tested to demonstrate its effectiveness when compared with other kinds of therapeutic interventions. Of course, this does not mean that it lacks effectiveness; rather there has been reduced commitment to empirical testing probably owing to insufficient support from the therapeutic-analytic community. (Silverman, 2005, p. 306)

As with other psychodynamic approaches that explore intrapsychic concerns, psychological constructs of Adlerian therapy may be hard to measure. For example, how does one measure how a dream is reflective of one's style of life? Or would it be reasonable, or even possible, to examine a changing subjective final goal? And if yes, how would one measure such a vague construct?

Sperry (2018) calls on Adlerian practitioners, researchers, and educators to ensure that Adlerian therapy remains a viable tool to foster client wellness and psychological growth by building its research base. Individual psychology, and its assumptions and techniques, offer counselors an approach that aligns well with the typical counseling practice today that is short-term, psychoeducationally oriented, and solution focused. Furthermore, its emphasis on building a trusting and egalitarian relationship to support client change and growth is consistent with research that demonstrates the importance of common factors in therapy (see Wampold & Imel, 2015). Carlson et al. (2006) also note that Adlerian therapy's antideterministic emphasis on encouragement and client hope and expectations embodies many of the characteristics that would speak favorably for positive client outcomes. Furthermore, several studies have examined specific elements of Adlerian therapy, such as the importance of birth order, early recollections, social interest, (Carlson et al., 2006; Watkins & Guarnaccia, 1999; Watts & Shulman, 2003) as well as the construct of perfectionism (Gnilka et al., 2017).

For several decades, Adlerian therapy and its constructs have been promoted in play therapy with children—an example of the creative therapies characteristic of the theory. *Play therapy* is a clinical approach that allows a child, through play, to express how they interpret the world and what experiences or issues are of concern to them (Landreth, 2012). Furthermore, Adlerian play therapy has been shown to be a developmentally appropriate intervention that emphasizes social interest, resilience, and family atmosphere that can foster children from various cultural backgrounds to form a healthy cultural identity (Agarwal & Meany-Walen, 2019).

There are several studies demonstrating the effectiveness of Adlerian play therapy in individual and group counseling settings. For example, Adlerian individual play therapy has been demonstrated to reduce trauma symptoms in children (Evans, 2020), decrease the severity of hyperactivity and inattention in children with attention-deficit/hyperactivity disorder (Mirzaie et al., 2019), reduce children's maladaptive perfectionism and related anxiety issues (Akay & Bratton, 2017), as well as reduce elementary school students' disruptive behavior and increase their on-task behavior (Meany-Waley et al., 2014, 2016-2017). Adlerian group play therapy has also been effective in increasing on-task behavior in children (Meany-Walen et al., 2015) as well as increase their self-esteem (Wick et al., 1997). Adlerian play therapy has also been extended to adults. For example, Monakes et al. (2011) demonstrated success with adult male substance offenders, who experienced sand tray therapy as an adjunct to their cognitive-behavioral rehabilitative treatment.

In general, group counseling approaches from an Adlerian perspective have some initial support for their effectiveness. For example, college students in an Adlerian psychoeducational group reported increased social interest and authenticity (Ergüner-Tekinalp, 2017). Furthermore, South Korean women in an Adlerian group program reported decreased *hwabyung* symptoms (i.e., South Korean anger syndrome) as well as reduced depression and anxiety symptoms (Kim et al., 2020).

Individual psychology is a common foundation for numerous parent training programs (Lindquist & Watkins, 2014; Popkin, 2014), based on its assumptions that a democratic, authoritative style between parents and children is linked with developing socially desirable personality traits in children (e.g., higher academic achievement, better emotional adjustment, decreased substance use, and higher self-reliance; Sorkhabi & Mandara, 2013; Suldo & Huebner, 2004). Adlerian-based parenting programs have shown positive changes in parenting practices and child behaviors among Black families in the United States (Farooq et al., 2005) as well as Jewish and Arab families in Israel (Prinz et al., 2008). Caution must be applied, however, when working with culturally diverse families, as not all families value an authoritative parenting style. In fact, level of acculturation may play a factor in determining the efficacy of Adlerian parenting programs (i.e., more acculturated families are more likely to demonstrate "success," as defined by the programs; Aleksandrov et al., 2016).

Finally, Travis (2021) highlights the importance of additional randomized controlled treatment designs, multiple-baseline studies, and outcome research in general to demonstrate the efficacy of Adlerian therapy. Given the promising results of available studies, as well as the emphasis of the approach on building a trusting relationship, Adlerian therapy probably has much to offer. However, more controlled studies clearly need to be completed.

The Millers

The following shows Jake going through Adlerian therapy. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, see Chapter 1.

Jake in Adlerian Therapy

Sitting behind the wheel of his SUV, Jake watched his children disappear into the front entrance of East Elementary, aware of a nagging sense of dread. "I just know something is going to happen to those kids. Why won't Angela just teach them at home? It doesn't make any sense!" His heart began to pound. Jake took several long, slow breaths, checked the rearview mirror, and pulled out of the parking lot, feeling helpless and guilty somehow. Jake realized his life had become consumed by his anxiety. Lately, he has felt on the verge of panic, constantly distracted by fantasies of potential catastrophe and imagining ways to prevent disaster. Though his relationship with Angela and his children, Luke and Celia, had once been a source of connectedness, satisfaction and pride, he found himself completely distracted by what he felt sure were irrational fears.

Ken Roberts, an Adlerian counselor, a stout man in his mid-forties, offered Jake a seat. The room was warm and reminded Jake of his parents' house, with its dated wood paneling and the orange shag carpet that had seen better days. "I haven't been able to get the landlord to change that carpet, but I'm working on it," Ken offered, noticing his gaze. "Why don't you tell me a little about why you are here, Jake."

"Sure—well—um," Jake stumbled, "I was dropping the kids off at school a couple of days ago, and as they were walking into the building, I just started to worry about all the things that could happen to them, especially Celia. I think about that a lot; it has been really distracting me lately. Well, as I watched them go into the building, I felt my breathing get faster and faster, and my heart was pounding like crazy." Jake caught his breath and continued, "The cars behind me started to honk, and I felt really confused. I stepped on the gas and a kid ran out in front of me! I stopped in time, and the kid wasn't hurt, but … I just think this is getting out of hand. I felt a little like that this morning before I came here, you know, a little panicked when the kids went to school. Anyway, that was the morning I decided I had to talk to someone, so I called you."

"Sounds like nearly hitting that kid in the parking lot was the last straw. This anxiety about your kids seems to have you by the throat," Ken replied.

"That's exactly what it's like, as if someone has his hands around my throat all the time! Is this something you can fix, Dr. Roberts? I've had anxiety problems before; this time I want them gone for good."

"Jake, I think this is something we can work on together; it is certainly something you can get a handle on and move on to another chapter in your life," Ken reassured. "I think a good place to start might be to find out a bit more about you. I wonder if you would be willing to take this home." Ken handed Jake a packet. "It is a 'lifestyle assessment.' If you don't mind, fill it out and bring it with you next time, so we can talk about it."

As an Adlerian therapist, Ken viewed counseling in phases. As he reflected on the first session with Jake, he felt the first phase, building the therapeutic relationship, had gone well. They were beginning to build their relationship, and he had used most of the skills important at this phase, including showing empathy and being nonjudgmental, respectful, optimistic, and egalitarian. Ken felt Jake was ready for the next phase: assessing and understanding the lifestyle.

Jake returned the next week remembering to bring the packet Ken had asked him to complete. He placed it on the coffee table. "You should have warned me about that thing. It really got me thinking about my family and my childhood," Jake said, easing into a frayed brown chair. "And, it took a long time," Jake said, somewhat irritated.

"I guess you were caught off guard by this homework. I'm curious about what this activity brought up for you," Ken began.

"Thinking back to when I was a kid kind of threw me. I think a lot about my sister's accident and even talked to a counselor once about it. She had a brain injury when we were young. But I hadn't thought a lot about much of anything in my childhood and what was surprising was all the memories it brought back. I was really surprised when I realized ... this is going to sound funny ... how distant our folks were from us before the accident. Justine and I just had our own world with no one else in it. And after the accident, I felt really alone. In a way, I lost a lot from that accident, just as Justine did, really. It's really confusing. I felt so angry, so scared, and so guilty all at once, you know."

"I hear all the strong feelings you had both before and after the accident," Ken replied. "Sounds like you had a special relationship with Justine, and the accident really impacted you in more ways than you realized. I also see that you had listed some traits for yourself and some for your sister Justine on the assessment. I noticed that you have put both 'helpless' and 'brave' for Justine and 'fearful' and 'responsible' for yourself. Can you tell me a little more about that?" Ken asked, handing Jake the packet he had filled out the week before.

"That sounds contradictory, I know, but Justine was really brave when we were kids, to the point of being reckless, actually. But, like I said, she isn't really independent anymore since that accident, so she is also 'helpless.' On the other hand, I guess I started out being kind of scared all the time when we were kids—I mean, before the accident. I guess I have my fears now, too. But I'm responsible."

"When you say 'responsible,' what does that word mean to you?" Ken asked.

"You know! Guilty—the cause of Justine's injuries," Jake replied, sounding vaguely irritated.

"I guess I asked, Jake, because that's a word that can mean accountable, like you said, or it can mean someone who is conscientious or trustworthy, or even the person who is expected to deal with problems," Ken offered.

"You know, that's about the size of it. I felt guilty and responsible, and now I feel like I have to take responsibility to see that nothing bad ever happens again," Jake replied. "Sometimes, that need to keep control over everything pushes me so much it gets in the way of everything else."

In his work with Jake, Ken began hypothesizing that Jake had tried to compensate for his early fears and feelings of inferiority through a need to control others. Jake seemed to hold a private logic that tells him that if he is in control, nothing bad will happen. This private logic has led to a subjective final goal of wanting to be the perfect protector. Ken has pointed out to Jake that his

efforts to protect his family by controlling them are not working for him. His anxiety and panic attacks had Jake and his family in a virtual prison of fear.

Walking into Ken's office for his next appointment, Jake paused a moment before taking a deep breath and sitting down. "You seem really wiped out, Jake, what's up?" asked Ken.

"I didn't sleep well last night," Jake began. "Yesterday at dinner everything seemed fine, when all of a sudden I found myself in the middle of another argument with Angela. I had been bossing her around and telling her how she ought to be doing something—I can't really remember what it was. Luke started acting out, so I yelled at him and sent him to his room. Angela and I have been fighting a lot lately, but there was something about this fight—I don't know, I just couldn't sleep."

"You found yourself in the same old pattern of fighting with Angela, but there was something that struck you about it that you just can't put your finger on. Jake, do you remember what you were feeling before the fight began?" Ken asked.

"Well, now that you mention it, I remember before dinner Angela had said that it might not be a good idea for me to go to this conference I was thinking of going to. She said that I seemed really stressed lately, and she thought I should take some vacation time to rest and just let someone else at the office go to the conference. I was irritated, but I also thought she was right. After all, I can't go to Los Angeles and have a panic attack, can I? I felt so worthless."

"What did it remind you of?" Ken probed.

"In the moment, I don't know if it reminded me of anything, but now that you mention it, it was just like when Justine would talk to me in a way when she knew that I wasn't up to the challenge—or worse yet, that I was scared, and she wasn't. I don't know if this makes sense, but it seems like every time I start to feel inferior, I take it out on Angela. It's kind of interesting—I act that way toward my mother, too."

Sitting at his desk and writing his session notes, Ken noted that Jake had moved successfully into the third phase of therapy: insight and interpretation. By exploring dreams, early memories, and Jake's family constellation, Ken anticipated that Jake would become more aware of the childhood feelings of inferiority he had toward his more outgoing and daring sister. Ken hoped that as Jake begins to realize that he is compensating for his feelings of inferiority with his attempts at controlling others, particularly women such as his wife, he would develop motivation to change his behaviors.

Near the end of their weekly session Ken and Jake sat together for some time before Jake broke the silence. "If only I had just said 'no!' I could have stopped the whole accident from happening. I can't let something like that happen to my wife or kids. I have to put my foot down, especially with Luke."

"It sounds to me that you think that it is somehow possible for you to prevent all possible disasters if you can just perfect your job as the protector. I'm not sure that it is really possible for anyone to have that much power over the universe," Ken offered.

"I hadn't really thought of it that way, Ken, but you are right, of course. What is it that E. E. Cummings wrote, 'Mistakes were born to happen'? I want to believe that is true, but I haven't allowed myself to accept that some things are out of my hands," Jake said, sounding surprised at his own realization. "I came in here thinking my problem was my anxiety, but it's my marriage and how I treat my kids, too. I'm afraid I'm going to lose my wife and that my kids will hate me."

"Jake, what if you tried doing something different when you started to feel inferior or worthless, something other than acting superior to Angela or trying to control the kids?"

"I don't know if I can do anything different. I've been doing this so long." Jake sighed, sounding defeated, "It seems to happen before I've thought about it."

"I'll tell you what, Jake, sometimes we don't have to know how to do things differently—sometimes just acting as if we do paves the way to making changes," Ken offered.

"You mean like fake it till you make it?" Jake asked.

Ken laughed. "Yep, that's a good way to describe it. Jake, there is something else we can try, too. We could do some role-playing; that would give you a chance to try out doing things differently without worrying about making mistakes. If you like, we could start next week," Ken offered.

As Jake's awareness and understanding grew over the next few weeks, Ken encouraged him to begin to make changes in his life. As they entered the fourth phase, reeducation and reorientation, Ken challenged him to try to respond differently at home with his wife and children. Ken began using an intervention, "spitting in Jake's soup," by pointing out how his attempt to control his wife's behavior ends up distancing her—something Jake clearly did not want. Ken felt confident that as they continued their work together, Jake would be able to transform his deeply entrenched style of living. Ultimately, he had taken the first steps in these efforts by encouraging Jake to try new, more effective ways of communicating with his wife and children and by encouraging Jake to let go of his attempts to control their behavior. Ken also believed that by encouraging Jake to "act as if" he is a person who can communicate effectively and can allow his wife and children to have their own identities, Jake can begin to let go of his old style of life and adopt a new, healthier one.

"You look like you are bursting with something," Ken commented as Jake took a seat. Jake handed him an envelope and motioned for him to open it. Ken skimmed the letter. "Well, congratulations, Jake. I'm not sure what all this means, but it looks exciting."

"A couple of weeks ago, I got an email. It was my boss asking me if I would be interested in sitting on a new committee for the National Association for Child Safety. They were looking for an engineer to consult on some of their upcoming initiatives. At first, I thought it must be some kind of mass email. It looked really interesting, but I just didn't think it was something I could do. But then, I remembered what you said about acting as if I could. I talked to my boss, and he said he thought of me for the committee right away. I was not sure I was up to it, but I filled out the application anyway. Well, they called me, and I'll tell you—at first, I felt really intimidated, but I remembered how we had practiced in those role-plays about being confident and persuasive, but not bossy—it must have worked. I got this letter this morning. I'm going to be part of something that might really make a difference to my kids' safety and to the safety of others. I can't wait!" Jake said grinning from ear to ear.

"I've noticed some changes with Angela, too. I've been trying to listen to her, and I do my best to control my temper when I start to get that inferiority feeling coming over me. I'm not sure Angela has noticed, but we haven't been fighting as much. It's been nice," Jake said with a look of relief. "I am also trying to let go of controlling everything my kids do. I actually let them play out in the yard the other day—and I wasn't even watching them—well, hardly watching, at least."

Ken was excited for Jake; he was pleased with the progress Jake had made in their short time together. Jake was beginning to try to act differently with Angela by improving his communication skills and not using a controlling tone with her. He had begun to let go of his need to watch over his kids every minute of the day. And he had become active in a program that had the potential to benefit both his kids and the larger community. His letting go of his narcissistic need to control had allowed him to begin to see outside of himself. His anxiety was no longer controlling him, and he reported being a calmer person—both calmer for himself and calmer with others. Ken felt confident that Jake was on his way to feeling whole and to gaining a sense of purpose in life as he focused on and continues to develop this new style of life, which is more in line with who he really is, rather than a reaction to his early feelings of inferiority.

For You to Consider

1. How did Ken change the focus of Jake's problems?
2. What was the purpose of the lifestyle assessment? Would you consider using a lifestyle assessment in your own work?

3. What early experiences and early memories have combined to develop Jake's current style of life?
4. How has Jake compensated for his early feelings of inferiority?
5. What kind of subjective final goal has Jake developed, and how has his private logic supported this goal?
6. Why is Jake's current style of life dysfunctional?
7. Do you believe Jake's career choice and his decision to become involved with the National Association for Child Safety is a function of his subjective final goal? Why, or why not?
8. What stumbling blocks might you foresee occurring with Jake as he goes through the therapeutic process using this approach?
9. Using Jake as an example, make an argument for why this type of therapy could be considered psychodynamic, existential–humanistic, or constructivist.
10. Adlerian therapy has often been applied with children. Using Celia or Luke as examples, from an Adlerian framework, respond to the following questions if you were to see them in therapy:
    i. How might you gain their trust?
    ii. What techniques would you use to gather information from them?
    iii. Given the information you already have from the introduction to the family, what clues do you have about their developing lifestyles?
    iv. How might you help these children gain insight into their behavior?
    v. In what ways are Celia's anxiety and Luke's reluctance to listen a function of the family dynamics? How do these behaviors work for them? How are they dysfunctional?
    vi. How might you help each child develop healthier ways of being?
    vii. Do you see any advantages to all members of the family getting together and discussing their issues? Why, or why not?
    viii. Can you identify your style of life and some of the memories and experiences you have that have gone into creating it?

Summary

Alfred Adler, the son of a Jewish grain merchant, grew up in Vienna, Austria and developed a theory of counseling that focused on how a young child's responses to feelings of inferiority would direct the child and, later, the adult toward healthy or unhealthy behaviors, or what he called the "style of life." A sickly child until the age of five, Adler, who had a "model" older brother, experienced firsthand what it was like to feel "less than" in life. Out of the memories of these experiences, Adler became driven to understand how such feelings could permeate and affect the lives of all individuals. At first, intrigued with some of Freud's notions, Adler developed his own theory that stressed a holistic perspective. Considered a psychodynamic theorist by some, an existential–humanist by others, and, more recently, a cognitive and a social constructivist, Adler believed that the whole person was driven by one drive—a striving for perfection. This force subsumed all other instincts but could be diverted from its natural path if the child had not learned how to effectively deal with feelings of inferiority.

Adler believed that each child is born with unique capabilities and personality characteristics and develops ways of responding to feelings of inferiority. Primary inferiority feelings are experienced by all of us as we stumble through life and make natural mistakes. Positive responses to these stumbles lead a person to develop private logic that is naturally in tune with our unique abilities and aptitudes. These individuals tend to become healthy, have good common sense, are altruistic, and care about the common good. Negative responses to these stumbles result in secondary inferiority feelings, which lead to faulty private logic, compensatory behaviors, little common sense, and more of a neurotic and narcissistic style of life.

Based on our feelings of inferiority and within the first five years of life, one develops a schema of apperception, or cognitive rules, that impact one's private logic. Private logic is the architect for our subjective final goal, which is the image of what the person wants to be, and this goal is eventually reflected in the individual's style of life as we try to strive for perfection and wholeness. Private logic that is not impaired by feelings of inferiority leads to common sense, where the person's developing attitudes, beliefs, and behaviors benefit the common good. Private logic that is faulty warps our common sense.

In working with clients, Adler believed that early experiences and the memories of those experiences deeply affected the development of an individual's private logic and subjective final goal as we strive for perfection and wholeness. Such things as birth order, major events in a person's life, and types of parenting could all affect the development of the child's private logic. Thus, it is important to do a thorough assessment of the individual to understand the development of an individual's private logic, subjective final goal, and resulting maladaptive and neurotic compensatory behaviors.

Techniques for adults include building a trusting relationship, encouragement, assessment, examining early recollections, exploring the family constellation, dream analysis, Socratic questioning and use of the dialectical method, teaching and interpretation, "spitting in the client's soup," guided imagery exercises, role-playing and acting "as if," catching oneself, and task setting. For children, they include building a trusting relationship; encouragement; art, play, and creative therapies; limit setting; natural consequences; logical consequences; assessment; responding to identified behaviors; democratically held discussion groups; catching oneself; task setting; and commitment and practice. Many of the techniques devised for children were developed by Rudolph Dreikurs and Don Dinkmeyer, who suggested four styles that children tend to adopt to compensate for feelings of inferiority: attention seeking, the use of power, revenge seeking, and displaying inadequacy (e.g., withdrawing).

Today, most Adlerian therapists view therapy as occurring through four phases: building the therapeutic relationship; assessing and understanding the lifestyle; insight and interpretation; and reeducation and reorientation. Courage to take responsibility and make change is encouraged by Adlerian therapists as clients work through the phases.

Relative to social and cultural uses, Adlerian therapy is well aligned with culturally responsive practice. Adler believed that oppression, such as child abuse, oppression of women, oppression of minorities, and war, was ultimately rooted in feelings of inferiority—in that those who felt inferior compensated by acting superior. He also highlighted the fact that one's values are handed down to us by both our family and society, such as the concept that males are superior. But he noted that through counseling and education, individuals can understand their misguided private logic and subjective final goals and develop new goals more in line with one's unique abilities and characteristics and which lead toward the development of a person who is empathic, loving, cooperative, and self-knowing and who works for the betterment of society. As for spiritual issues, Adler believed that God symbolized perfection and is an image that is important for individuals to model in their quest for completion and wholeness. However, he also warned about how religious dogma can be abusive.

Although research on individual psychology is limited, it was noted that many of the qualities inherent in the Adlerian therapeutic relationship are qualities that have been shown to be important for effective client outcomes. Specific elements of Adlerian therapy, such as the importance of birth order, early recollections, and social interest, have been shown to be efficacious in research studies. With children, Adlerian-based play therapy and group counseling have been shown to be beneficial to children, particularly in treating trauma, hyperactivity, perfectionism and related anxiety issues, task behaviors in schools, and self-esteem. Play therapy as well as group counseling has also shown some limited success with adults.

Key Words and Terms

art, play, and creative therapies
antideterministic
assessing and understanding the lifestyle
assessment
attention seeking
birth order
building a trusting relationship
building the therapeutic relationship
catching oneself
commitment and practice
common sense
compensatory behaviors
courage
democratically held discussion groups
developing an understanding of self and others (DUSO)
dialectical method
displaying inadequacy
dream analysis
early recollections
encouragement
family constellation
feelings of inferiority
fictional final goal
gemeinschaftsgefühl
guided imagery
guiding self-ideal
holism
individual psychology
insight and interpretation
latent meanings
limit setting
logical consequences
manifest meanings
meta-therapy phase
natural consequences
organ inferiority
primary inferiority feelings
private logic
reeducation and reorientation
responding to identified behaviors
revenge seeking
role-playing and acting "as if"
schema
schemas of apperception
secondary inferiority feelings
social interest
Socratic questioning
spitting in the client's soup
striving for perfection
striving for superiority
striving for wholeness
style of life
subjective final goal
Systematic Training for Effective Parenting (STEP)
task setting
teaching
teleology
use of power

Key Names

Adler, Alexandra
Adler, Alfred
Adler, Kurt
Adler, Nelly
Adler, Sigmund
Dinkmeyer, Don
Dreikurs, Rudolf
Epstein, Raissa Timofeyewna
Freud, Sigmund

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SECTION II

EXISTENTIAL–HUMANISTIC APPROACHES

Section II offers an overview of three important existential–humanistic approaches to counseling and psychotherapy: existential therapy, Gestalt therapy, and person-centered counseling. Existential–humanistic approaches have a client-centered focus, while stressing the importance of the therapeutic relationship. These three approaches focus on all aspects of the person, including their physical, social, psychological, and spiritual worlds. These approaches were particularly prevalent during the latter part of the 20th century but continue to be widely used today.

As existentialism examines the kinds of choices one makes to develop meaning and purpose in life, these approaches suggest that people can choose new ways of living at any point in their lives. With this philosophy as the background, these approaches focus mostly on the "here and now" and, in different ways, encourage clients to make new choices in their lives. Embracing a phenomenological perspective, these approaches have the belief that each person's reality is unique, thus each approach stresses the importance of listening carefully to the subjective experiences of the client to understand how that person has come to make sense of their world. Although each of these approaches adheres to the basic philosophies of existentialism and phenomenology, the manner in which they implement their approaches to apply these philosophies differs widely.

Although generally shorter than the psychodynamic approaches examined in Section I, these therapies tend to be longer than the cognitive-behavioral approaches you will explore in the next section of the book. Accompanying this text is a video file that provides a role-play for each therapeutic approach being presented in Chapters 2 through 13. In addition, a separate video file that illustrates an integrative existential–humanistic approach with Jake Miller is provided with the book.

5 Existential Therapy

Learning Goals

At the conclusion of this chapter, readers will:

- be familiar with the life of Viktor Frankl and understand the historical context in which Frankl created his theory
- understand the roles existential philosophy and phenomenology play in the development of existential therapy's antideterministic view of human nature
- have knowledge about key concepts that are the basis for a generic approach to existential therapy, including phenomenology; death and nonbeing; choices and freedom; responsibility; meaninglessness; existential and neurotic anxiety; neurotic or moral guilt and existential guilt; will to meaning; and authenticity
- be able to articulate major techniques used in existential therapy, including the dialectical method; educating the client about existential therapy philosophy; developing an authentic relationship; using a phenomenological perspective; acceptance; confrontation; encouragement; paradoxical intention; and dereflection
- be familiar with the therapeutic process and its eight phases, including: contact, understanding, education and integration, awareness, self-acceptance, responsibility, choice and freedom, and separation
- understand important social, cultural, and spiritual issues related to existential therapy, especially in reference to the notion of *Mitwelt*, or the social world, and examine the role the therapist has in helping a client examine their spiritual life
- be able to identity client concerns where existential therapy might be most helpful, highlight factors that support the efficacy of existential therapy, and acknowledge the difficulty in measuring the outcomes of this approach

In this first chapter on existential-humanistic approaches, we highlight Viktor Frankl, who was one of the first therapists to popularize existential therapy. Many would place Fritz Perls and Carl Rogers, also highlighted in this section, in this general school (discussed in Chapters 6 and 7, respectively). We focus upon Viktor Frankl because of his compelling life story that brings forth so many of the philosophical issues basic to existential therapy. However, this chapter presents a generic approach to existential therapy, as opposed to Frankl's specific approach (i.e., *logotherapy*, or meaning therapy). Using this lens, we examine the existential therapist's view of human nature;

key concepts to a generic approach to existential therapy; techniques used in this approach; the existential therapeutic process; social, cultural, and spiritual considerations; and efficacy research, regarding the practice of existential therapy. We conclude the chapter by applying existential therapy principles to Jake, a member of the Miller family.

Viktor Frankl

It was 1941, and the Nazis occupied Austria. *Viktor Frankl*, a prominent physician at a hospital in Vienna is suddenly handed a visa that would allow him to leave his beloved Austria. Few Jews were afforded this opportunity, and many were already being sent to concentration camps, although the extent of the atrocities was not yet known. Suddenly, Frankl had to decide between leaving his parents and the country he loved and staying and hoping that his status at the hospital would continue to afford some protection for him and his parents—protection that was becoming less and less likely. He agonized about what to do as he walked home. Upon entering his house, he saw a piece of the Ten Commandments marble tablet from his destroyed family's synagogue:

> If Frankl were to look closely, his father pointed out, he would recognize which commandment it came from. At that moment, Frankl's father began to recite in Hebrew the fourth commandment: "honour your father and your mother, that your days maybe be prolonged in the land which the Lord your God gives you!" (Exodus 20:12). Frankl felt as though he had been hit by lightning and knew instantaneously what his decision had to be. This was no sheer coincidence but a real "hint of heaven" for him. Frankl allowed the visa to expire and, 9 months later, the hospital he worked at was closed. He and his family (this included Frankl's first wife) were soon deported to the concentration camps. Only his sister managed to immigrate to Australia. (Längle & Sykes, 2006, p. 39)

Only 1 in 40 survived the concentration camps, and ironically, Frankl's time in the camps would become a mechanism for him to live the counseling theory of existential therapy, which he had begun to write prior to being sent to the camps. Ultimately, his theory and its hypotheses about human nature would become known throughout the world.

A middle child with an older brother, *Walter*, and a younger sister, *Stella*, Frankl was born in Vienna, Austria, on March 26, 1905, to *Elsa* and *Gabriel Frankl* (Frankl, 1943/2004). Frankl described his family as being close and remembers feeling safe while growing up, despite having been brought up during a time of world wars and rampant anti-Semitism. He recounted his parents having a deep sense of faith and described his father as being fair, principled, stoic, and determined and his mother as being kindhearted, pious, and warm (Frankl, 1997). He loved her dearly.

> In Auschwitz I thought very often of mother. Each time I fantasized how it would be when I would see her again. Naturally, I imagined that the only thing for me to do would be to kneel down and, as the expression goes, kiss the hem of her dress. (Frankl, 1997, p. 22)

As a child, Frankl had lofty expectations of himself, and even at the very young age of three, he remembered wanting to become a physician (Frankl, 1997). As he grew into his teen

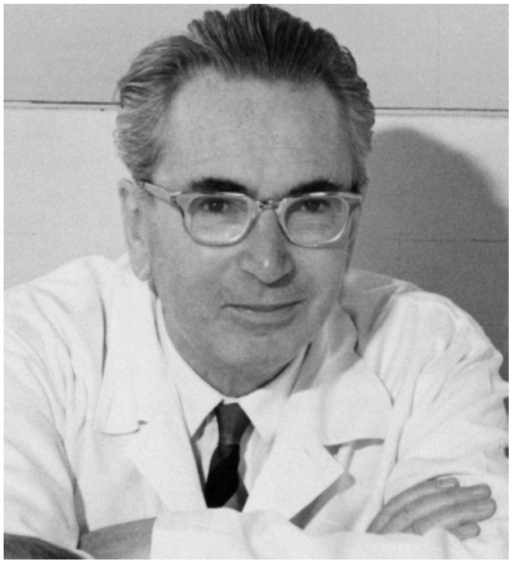

FIGURE 5.1 Viktor Frankl

years he discovered psychology and, at the age of 19, sent an article he wrote on mimicry to Freud. At Freud's urging, it was published in the *Journal of Psychoanalysis*. Eventually, Frankl studied medicine at the University of Vienna and specialized in neurology and psychiatry with a focus on depression and suicide. This was an exciting time in Vienna. Freud, who was Viennese, had taken the world by surprise with his theory of psychoanalysis, and soon after, *Alfred Adler*, also Viennese, was to become almost as popular. To live in Vienna, become a physician, and have a keen interest in psychiatry meant you would encounter and work closely with some of the icons of psychodynamic therapy.

Although initially intrigued with psychoanalysis (Batthydiny & Costello, 2015), Frankl's allegiance to the Freudian approach was short-lived, and by his early 20s he was questioning the psychoanalytic emphasis on childhood sexuality. He soon discovered the Adlerian approach of individual psychology, which was much more optimistic and future oriented. However, after a short affiliation with this group, he was to develop his own theory and open counseling centers for youth. His centers were quite successful, and despite still being a medical student, he was allowed to work as a therapist at the University of Vienna Psychiatric Clinic.

In 1930, Frankl received his medical degree, and two years later, at age 27, he became head of the *Steinhof Psychiatric Hospital,* where he worked with suicidal women (Batthydiny & Costello, 2015). Here, he pondered why some of the women were particularly set on killing themselves, while others seemed to be able to move on with their lives. It was then that his ideas about why certain individuals can maintain a sense of meaning in their lives, and thus ward off deeply painful feelings, began to coalesce in his counseling theory, which he would eventually call *logotherapy*. This approach would later be called the *third wave of Viennese psychology*, following Freud and Adler's approaches (Frankl, 1943/2004).

In 1938, the Nazis overran Austria, and Frankl would soon be faced with difficult decisions regarding his life and the lives of members of his family. In 1940, he became chief of neurology at the Rothschild Hospital, which was one of the only hospitals still employing Jews (Batthydiny & Costello, 2015). Here, Frankl would often purposefully misdiagnose patients to prevent them from being murdered by the Nazis. Thus, schizophrenics became "aphasics" (loss of speech functions), and diagnoses of major depressions became "high fevers with deliriums." In 1941, Frankl turned down a visa, which would have allowed him to leave the country, so he could stay with his parents and, due to his status, hopefully protect them from the Nazis. Later in that year, he married *Mathilde "Tilly" Grosser*. However, in 1942, he, his pregnant wife, and his parents were sent to a concentration camp. Here his mother would be gassed and his father would die of starvation and pneumonia. Frankl, who had managed to smuggle a vial of morphine into the camp, helped spare his father the horrors of his last moments:

> I asked him: "Do you still have pain?" "No." "Do you have any wish?" "No." "Do you want to tell me anything?" "No."
>
> I kissed him and left. I knew I would not see him alive again. But I had the most wonderful feeling one can imagine. I had done what I could. I had stayed in Vienna because of my parents, and now I had accompanied father to the threshold and spared him the unnecessary agony of death. (Frankl, 1997, p. 26)

His wife, Tilly, would be forced to have an abortion and eventually die in Auschwitz (Batthydiny & Costello, 2015). His brother, Walter, who had fled to Italy, was captured and would also die in a concentration camp. His sister, Stella, who had managed to immigrate to Australia, would be his only surviving family member.

When sent to the concentration camps, Frankl had hidden his initial manuscript for his theory in the lining of his coat. However, the coat was confiscated, and for the next few years, while in four different concentration camps, he began to rewrite his manuscript on scraps of paper, using a blunt

pencil given to him by a fellow inmate as a birthday gift. This book, in some ways, was motivation for Frankl to keep living (Frankl, 1997).

While in the camps, Frankl watched some fellow inmates maintain hope and survive, while others would dip into despair and die. Here he recognized that unless they had meaning in their lives and hope for their future, their psychological lives would cease, and their physical lives would soon end. Meaning, he believed, came from a will to take responsibility for oneself and to choose to live a life of dignity with purpose, despite one's predicament. Even when being taken to the death chambers, Frankl could distinguish those who would find some larger meaning and stand erect from those who had given up.

From his experiences in the concentration camps, Frankl relayed several poignant memories that highlighted the importance of having a sense of meaning (Batthydiny & Costello, 2015). For instance, he tells the story of a fellow inmate who told him he knew they would be liberated on March 30. Then, when this day came, and no liberation was in sight, this inmate suddenly became ill and died the next day. Other times, he would watch inmates put aside a cigarette, waiting for the moment when they were liberated to smoke it. Periodically, an inmate would lose hope, cease having any sense of purpose in life, and smoke the cigarette. Invariably, that person would soon die of illness or commit suicide. Frankl and others tried to do their best to prevent inmates from moving into despair—their first step toward death. He could often be found trying to reassure them that their lives had meaning, even in such a place.

Many of these stories, as well as Frankl's outline of his theory, were written in his best-selling book, *Man's Search for Meaning* (1946/2014), which Frankl dictated to his publisher in nine days. Listed as one of the 10 most influential books by the Library of Congress, the book has sold millions of copies and has been translated into dozens of languages. His next book, *The Doctor and the Soul*, published directly after *Man's Search for Meaning*, was the product of the scraps of paper he had written on while in the concentration camps (Frankl, 1946/2019). Frankl strongly believed that each person was responsible for their actions, and as an example of this, he refused to generalize anger, or what he called *collective guilt*, toward all Germans as was commonly done after the war (Lukas & Hirsch, 2002).

> In 1946, I lectured in the French occupation zone of Austria. I spoke against collective guilt in the presence of the commanding general of the French forces. The next day a university professor came to me, himself a former SS officer, with tears in his eyes. He asked how I could find the courage to take an open stand against collective guilt. "You can't do it," I told him. "You would be speaking out of self-interest. But I am the former inmate number 119104 and I can do it. Therefore I must." (Frankl, 1997, p. 103)

Frankl's philosophy regarding collective guilt explains one of the reasons he decided to return to Vienna following the war, even though Austrian resistance against the Nazis had been minimal. After returning to Vienna, Frankl was given the post of director of the Vienna Neurological Polyclinic and remained at the clinic until his death. In 1947, he met *Elenore "Elly" Schwindt*, with whom he fell in love and had one child, *Gabriele* (Batthydiny & Costello, 2015).

Over the years, Frankl would become involved in dozens of humanistically oriented professional associations, hold visiting and honorary professorships at such places as Harvard and Stanford Universities, write over 30 books and numerous articles that were translated into dozens of languages, and win dozens of awards for his writings and lectures (Viktor Frankl Institute, n.d.a). He became an avid mountain climber and, in his late 60s, learned how to fly planes. He died at the age of 92 of heart failure (see Box 5.1).

BOX 5.1 A Conversation with Viktor Frankl

Listen to Dr. Allen Ivey, Dr. Mary Ivey, and Dr. Jeffrey Zeig discuss conversations they had with Viktor Frankl by clicking on the Frankl link at the Stories of the Great Therapists website: http://www.odu.edu/sgt.

In 1992, Viktor Frankl's daughter, Dr. *Gabriele Frankl-Viseley*, and others, organized and cofounded the Viktor Frankl Institute with the purpose of fostering "the life work of Viktor Frankl and to provide access to authentic information about Logotherapy and Existential Analysis" (Viktor Frankl Institute, n.d.b, para. 1).

Viktor Frankl was undoubtedly influenced by a number of existential philosophers, theologians, and phenomenologists who came before or were his contemporaries. Some of these included *Søren Kierkegaard* (1813–1855), *Friedrich Nietzsche* (1844–1900), *Edmund Husserl* (1859–1938), *Martin Buber* (1878–1965), *Paul Tillich* (1886–1965), *Martin Heidegger* (1889–1976), and *Jean-Paul Sartre* (1905–1980; Rubin & Lichtanski, 2015). These individuals put forth some of the ideas that would impact Frankl's theory, such as: The world is an absurd place into which we are thrust against our will, anxiety is a natural part of living, self-awareness and consciousness should not be assumed, reality is a self-created subjective experience, relationships are critical to who we are and who we become, and the *choices* each person makes determines their essence ("existence precedes essence"). He was also likely influenced by *Ludwig Binswanger* (1881–1966), a pioneer in existential psychology, who developed one of the first approaches to working with clients and suggested the importance of understanding the physical and biological world of the client (*Umwelt*), the interpersonal and social experience of the client (*Mitwelt*), and the client's psychological understanding of self (*Eigenwelt*). It was individuals like Binswanger and Frankl, who took the esoteric writings of the existentialists and offered a new paradigm that was optimistic and offered possibilities for change (Rubin & Lichtanski, 2015). These theorists also challenged the reductionistic and deterministic theories of the analytical and early behavioral approaches by offering an approach that was considered antideterministic.

As Frankl was influenced by others, he too influenced many, including such famous existential therapists as *Rollo May* (1909–1994), *James Bugental* (1915–2008), and *Irvin Yalom* (1931–). May is often considered the founder of American existential therapy, while Yalom is often looked at as the person who popularized the existential approach to therapy, partly because of his bestselling novels, *Love's Executioner*, which was first published in 1989, and *When Nietzsche Wept*, which was first published in 1992 and was later adapted as a movie. These modern-day existential therapists looked at the importance of the relationship in defining who we are and viewed the change process as a journey between therapist and client in which both are deeply affected. In their view, therapist openness and self-disclosure are critical to the therapeutic process and likely to lead to the same on the part of the client (see Box 5.2). In addition, the influence of Frankl, and other existentialists, can be seen in the views of human nature of most existential–humanistic therapies, such as Gestalt therapy and person-centered counseling (see Chapters 6 and 7, respectively). This chapter integrates the philosophies of many well-known existential therapists into one coherent approach.

BOX 5.2 Want to Meet Viktor Frankl?

Want to hear a brief biography about Frankl from the man himself and find other tidbits of information about him? Go to https://silver.odu.edu/psyadm/ to see a caricature of Frankl talking about himself and his theory. Click on the existential–humanistic door and go into Frankl's office.

View of Human Nature

Existential therapists believe that people are born into a world that likely has no inherent meaning or purpose (Rubin & Lichtanski, 2015). People are not born good or bad; they are just thrust into the cosmos. Whether there is broader meaning to existence (e.g., God, a "larger purpose" to life) one will never know, and although some may choose to have faith in something "more," such beliefs are unfathomable constructs that cannot be proven. Since life has no inherent meaning, each of us is charged with the responsibility of making it meaningful through the choices we make. Although not discussed in detail, most existential therapists agree that the

ability to face life's struggles and bring meaning into one's life is at least partially related to the kind of parenting one receives. However, in existential therapy, one need not unravel years of early childhood issues to uncover core concerns that affect one's ability to do this. In fact, existentialist therapists reject the notion that we are determined by early childhood development, instincts, or intrapsychic forces, although talking about the past is not avoided if clients believe it would help them understand themselves in more meaningful ways.

Central to existential therapy is the belief that all people struggle with basic questions of what it is to be human, such as the fact that we are born alone, will die alone, and except for periodic moments when we encounter another person deeply, we live alone; that death constantly looms over us and reminds us of the relatively brief amount of time we have; that we alone are responsible for making our lives meaningful; and that meaningfulness, as well as a limited sense of freedom, comes through consciousness and the choices we make (Yalom, 1980). However, existential therapists believe that most people avoid examining these issues and, instead, live a life of limited self-reflection. After all, it can be scary to accept one's aloneness in the world, can be frightful to be cognizant of one's ultimate demise (death), may be humbling and anxiety provoking to examine whether one is living a meaningful existence, and takes focused self-discipline to change the way one has been living. In essence, we can live authentically by facing our inherently human struggles, which will, at times, lead to feelings of anxiety, depression, and dread, or live an inauthentic, neurotic, and maybe even psychotic unaware existence if we do not.

Existential therapists suggest that through dialogue with others, people can gain a greater awareness of the choices they have made and can begin to direct their lives toward a more purposeful, meaningful, and authentic existence by making new choices that involve facing life's struggles honestly and directly (Leszcz, 2015). With this awareness, however, comes a great sense of responsibility, as one comes to realize that every choice made affects ourselves, those close to us, and, to some degree, all people on the planet, as each decision has a ripple effect throughout the world.

As you might imagine, existential therapists believe that uncomfortable feelings or neurotic symptoms are important messages regarding the maneuvering one engages in to avoid the ultimate questions of living (Rubin & Lichtanski, 2015). Sometimes, behaviors people develop in this process can be quite odd yet are in response to the same issues haunting each of us. In fact, they would say that there is little difference between the obsessive–compulsive, germophobic neurotic who walks the streets with his pet goldfish around his neck (such as in the movie *What About Bob*) and the executive who is obsessively driven by her work and puts in an 80-hour workweek. They both have developed ways of avoiding facing the basic questions of life and encountering others in an authentic manner.

Many of the humanistic approaches to counseling share much in common with the existential approaches, and therefore, you see these approaches subsumed under the general heading of existential–humanistic approaches to counseling. For instance, both the existential and humanistic approaches are *holistic* (nonreductionistic) and *antideterministic*, believe in the power of choice in redefining the person, view the client and therapist relationship as critical to the therapeutic journey, have a *phenomenological perspective* that highlights the client's subjective experience, and are *optimistic* about the individual's ability to change (Cain et al., 2016; see Figure 5.2).

FIGURE 5.2 Cartoon

However, differences exist between existential and humanistic therapies. First, existential therapies tend to directly focus on "existential issues" and discussing such topics as how clients make sense of their lives in light of their eventual demise, how they deal with their aloneness in the world, how they make meaning in their lives, how they manage their anxiety of living (and dying), and the realities and consequences of the decisions they make (Cain et al., 2016; Rubin & Lichtanski, 2015; van Deurzen, 2012). In contrast, the humanistic approaches tend to have clients self-direct their sessions and believe that people are born with an inherent growth force that will lead them toward a state of self-actualization and harmony with self if they are in an environment (e.g., the therapist's office) that allows clients to access their true self. Some of the core beliefs of existential therapy are summarized in Table 5.1.

TABLE 5.1. Core Beliefs of Existential Therapy

1. We are born into a world that has little inherent meaning.
2. We are born alone, and we will die alone.
3. We alone make our lives meaningful.
4. We bring meaningfulness into our lives through the choices that we make.
5. Meaningful choices only occur if we are conscious of our aloneness and our limited time on earth.
6. Anxiety, feelings of dread, and struggles in life are a natural part of living and are important messages about how we make meaning in our lives and relate to others.
7. Limited freedom is experienced through the realization that we choose our existence.
8. With recognition that we choose our existence comes the responsibility to choose wisely for ourselves and to recognize how those choices affect those close to us and all people.

Key Concepts

Some of the key concepts that are the basis for a generic approach to existential therapy include phenomenology; death and nonbeing; freedom; responsibility; isolation; meaninglessness; existential and neurotic anxiety; neurotic or moral guilt and existential guilt; will to meaning; and authenticity (Rubin & Lichtanski, 2015; van Deurzen, 2012).

Phenomenology

Phenomenology is a branch of philosophy concerned with the nature of reality and emphasizes subjective experience as a way of approaching and understanding truth. From this perspective, each thought, reflection, and experience a person has should be understood as meaningful and provides a window into that person's understanding of truth. This contrasts with trying to understand a client by applying an external model or frame of reference, as do many other therapeutic approaches (van Deurzen & Kenward, 2005). Individuals who take on a phenomenological perspective assume that the client's experience of self is unique, real to that person, and ever-changing as the individual lives in the world and interacts with others. A phenomenological perspective calls for the therapist to be nonjudgmental, for one cannot judge another's experience if they believe truth is a function of the person's unique understanding of the world. Does such a perspective mean there is no reality? Although this can be debated, most people would agree that certain things exist (e.g., cars, the earth, or climate); however, there is likely to be disagreement on the purpose or meaning of such objects or concepts as they get filtered through our unique subjective experiences (see Box 5.3).

BOX 5.3 Did He Really See That Eagle?

The phenomenological perspective can be seen in this incident of Billy Mills, an Olympic runner who "saw" something no one else saw. Read the following, and see if you believe that Billy saw the eagle:

> When Billy Mills was eight, his mother died. His father, a member of the Lakota nation in South Dakota, stroked the boy's arms and told him, "You have broken wings." He used a stick to draw a circle in the dirt. "Step inside your soul," he said. "It is the pursuit of the dream that will heal you."
>
> He encouraged his son to find his dream in sports, which were providing Native Americans with a new way to compete against the White man after centuries of slaughter and treacherous treaties. ... In the grueling 10,000-meter race during the 1964 Summer Olympics in Tokyo, 26-year-old Billy Mills, with his dark complexion and crew cut, was near the head of the pack. He was a virtual unknown, but he managed to stay neck-and-neck with the world record-holder from Australia. After the last lap bell, the Australian made his move, nudging Mills' elbow so he could break ahead. Caught off guard, Mills staggered and drifted to an outer lane.
>
> Spotting an eagle on the jersey of another runner, he heard his deceased father's voice, "You will have the wings of an eagle." In the final stretch, the race for the gold was down to the Australian and a top-ranked Tunisian. Then, out of nowhere, Mills came charging with the long, easy strides of a sprinter. The television announcer could hardly believe what he was seeing. "Look at Mills!" he cried. "Look at Mills!" As the American crossed the finish line first, the announcer, witness to one of the greatest upsets in Olympic history, just screamed in a wordless spasm of shock and glee, "Aaahhh!"

After the race, Mills realized that the eagle he had seen on the jersey hadn't actually been there at all. But the idea of it had been enough to propel him. He became the first American to win the gold in the 10,000-meter race. No one from the Western Hemisphere has done that since.

Box 5.3: Neil Swidey, Excerpt from: "The Jacoby Factor," *The Boston Globe*. Copyright © 2008 by Boston Globe Media Partners, LLC. Reprinted with permission.

Death and Nonbeing

> We are all dying, every moment that passes of every day. That is the inescapable truth of this existence. It is a truth that can paralyze us with fear, or one that can energize us with impatience, with the desire to explore and experience, with the hope—nay, the iron will!—to find a memory in every action. To be alive, under sunshine, or starlight, in weather fair or stormy. To dance with every step, be they through gardens of flowers or through deep snows. (Salvatore, 2001, pp. 11–12)

With life comes death. We burst into the cosmos and eventually must face our ultimate demise. And facing death is not an easy task, for if we have no illusions or faith to prevent us from accepting our fate, we assuredly would become anxious. However, we tend to find ways of avoiding this anxiety—ways of dodging the reality of our demise. These avoidant mechanisms prevent us from choosing more effective and selfless ways of living in the world (May, 1967).

For some, the same methods that are used to avoid awareness that the Grim Reaper is at the door allow them to live relatively calm lives and work with one another peacefully. For instance, some may blindly embrace beliefs in religion, God, a hereafter, or values that put their minds at ease about death. Others may take a hedonistic view of life. These individuals only see value in self-enjoyment, as they constantly try to have their needs met to momentarily take them away from worrying about death and nonbeing. Both types of individuals have found ways of avoiding the anxiety of *death and nonbeing* and have not made conscious choices about their beliefs or behaviors.

Ultimately, one of the goals of existential therapy is to help the client see one has avoided the anxiety of the knowledge of death and nonbeing—that is, to assist the client in understanding what mechanism they have used to avoid knowledge of their demise. And knowledge of avoidance mechanisms brings the client face to face with their death anxiety. Faced head-on, this reality allows the client to move forward, for it is only through such self-knowledge that one can decide whether to embrace one's former tactics for avoiding the knowledge of death and nonbeing or to choose a new way of being in the world—a way that is honest in its acceptance of one's ultimate fate and allows one to decide a new path toward a personally meaningful existence (see Box 5.4). And this new path does not necessarily mean that one gives up one's past values (e.g., religious values), but it does mean that the individual now chooses those values with consciousness and is aware of how those choices affect self and others.

BOX 5.4 My Death Anxiety

I (Neukrug) remember being 16 years old and sitting on the window seat in my room, looking out at the stars. Suddenly, the immensity of the universe hit me, and the reality of my limited time on earth came to bear. My heart started to beat as I began to have a panic attack. "I must stop this," I said to myself. "But how?" I wondered. I had started to experience my death anxiety and wasn't sure how to "turn it off."

Ultimately, we must all ask ourselves what beliefs or behaviors we have adopted to stop ourselves from experiencing the anxiety that results from facing the knowledge of our death and nonbeing. Then, we must see if we are brave enough to embrace this anxiety and decide whether we wish to keep our former avoidance mechanisms or to make choices that may lead us to a more meaningful existence.

Choices and Freedom

> [E]verything can be taken from a man but one thing: the last of the human freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way. (Frankl, 1946/2014, p. 104)

One can reflect about *freedom* on multiple levels. Those who are enslaved by others have little freedom to do and act as they wish. Those who are oppressed by others have their social freedom limited. Those who are poor have their economic freedom limited. And those who build psychological fences prevent themselves from choosing ways of being that would bring dignity and purpose to their lives.

Sometimes, individuals are oppressed by external factors, such as slavery, poverty, war, and disasters. In contrast, choosing dignity and purpose is an internal process that leads to a sense of psychological freedom. Thus, a group can fight against an external oppressor for years, decades,

and even centuries, but when freedom finally comes, it may still be enslaved because individuals within the group have not found inner freedom. Some even argue that true freedom has little to do with external restraints. After all, were not Jesus, Gandhi, Mother Teresa, Martin Luther King, Nelson Mandela, and Viktor Frankl free, even during their harshest moments?

Once one comes to recognize that freedom is as much of an internal process as an external one, one can begin to take steps toward ultimate freedom—freedom from self-created internal constraints. It is at this point that one can gain mastery over every step taken, every thought that occurs, every feeling that is expressed, and every attitude that is chosen. Such mastery can and will lead to a sense of dignity, as one purposefully makes *choices* that result in a dignified way of life. Any other choice would be foolish, as it would lead to existential guilt, or what some have called the "wronging of self" (Yalom, 1980; see Figure 5.3).

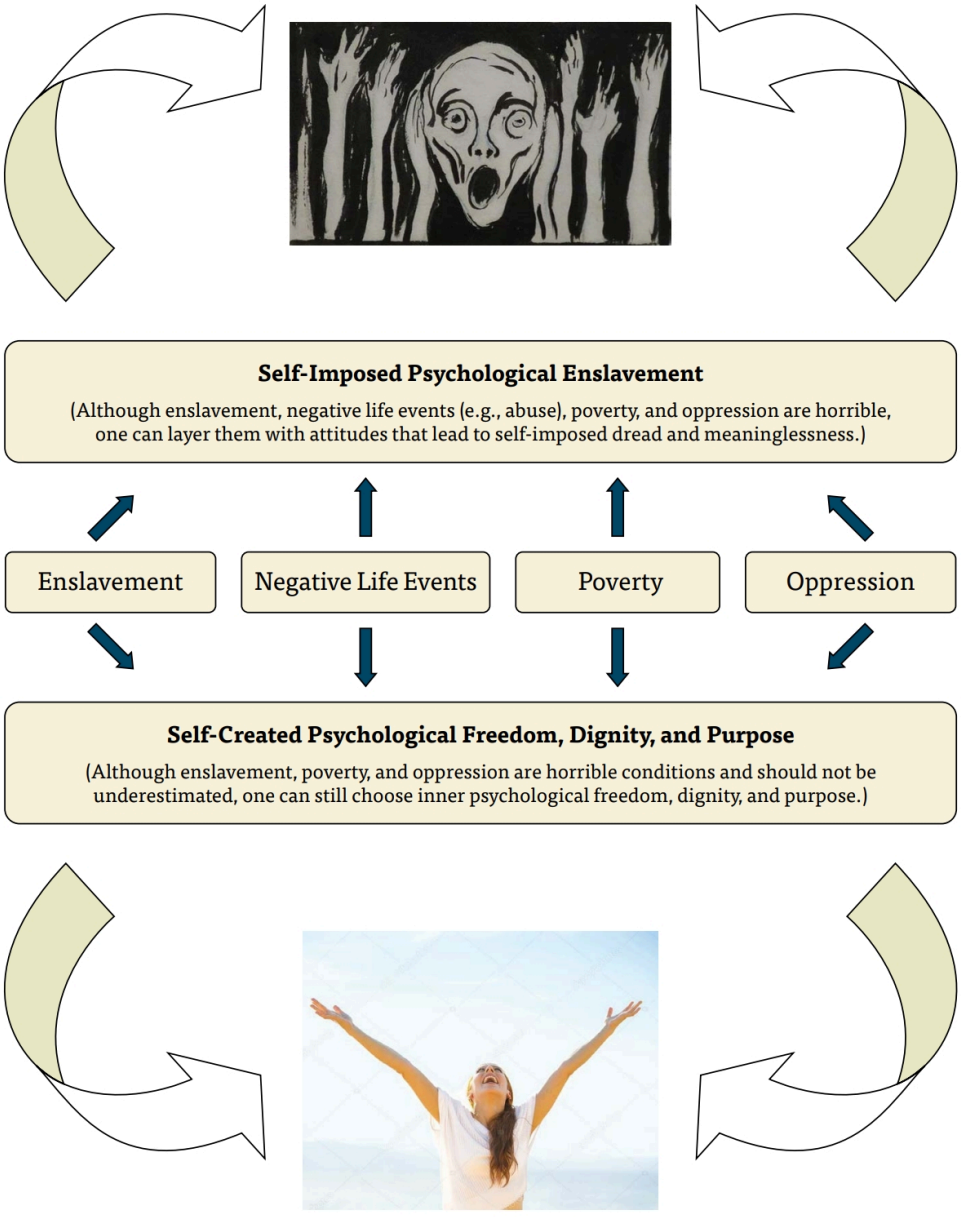

FIGURE 5.3 Enslavement Versus Freedom

Responsibility

Responsibility can be understood on two levels: toward the self and toward others (Yalom, 1980). Responsibility toward the self is intimately associated with one's awareness that freedom is internally created. With this knowledge, every choice made then becomes one that is directly related to living a dignified life with purpose. Having such consciousness weighs on a person, for how can a person choose not to be responsible if the consequences of one's choices are self-evident?

In 1972, meteorologist Edward Lorenz gave a talk in which he presented evidence that the flapping of a seagull's wing in Brazil could cause a tornado in Texas (Hilbon, 2000). Somehow, this later became known as the butterfly effect and was changed to how the wings of a butterfly could affect the weather in the United States. In either case, the point was that the smallest action in a part of the world could affect others in another part of the world. Having consciousness that every action we take will affect those around us and, likely, impact the world in some fashion is a monumental weight that carries with it a humbling responsibility. However, it is only by embracing this concept that we can have true peace and harmony in the world. It is only when each of us comes to believe in the butterfly effect that we can realize the effects of our actions on others. And when we do realize this, we will be responsible to others.

Typically, clients have spent years finding ways of avoiding consciousness around responsibility. In fact, Yalom (1980) identified several mechanisms that clients use to avoid responsibility. Like the psychoanalytic concept of defense mechanisms, they include compulsivity, displacement, playing the victim, losing control, avoiding autonomy, willing denial, and physical disease. You can probably come up with several other ways one avoids taking responsibility:

- **compulsivity:** This is the quality of becoming so consumed with an activity that a person avoids examining their life. The "activity" overwhelms the person. These days, we see compulsive behaviors all around us, such as compulsive eating, sex addiction, working unreasonably long hours, and so on. The underlying question that therapists want to ask their clients, and clients need to eventually ask themselves, is: "What is being avoided by these behaviors, and how is this avoidance keeping you from freedom?"
- **displacement:** This is the process of placing one's problems or issues onto others or other things, so one does not have to take responsibility for examining them. Displacement happens in numerous ways, such as projecting one's issues onto others, having a psychosomatic illness to avoid one's issues, blaming others for one's problems (e.g., "If only my therapist was better at this!"), or blaming events for one's problems (e.g., "If it wasn't for the job demotion, I'd be happy").
- **playing the victim:** "I did not make the team." "My boss is racist." "My parents emotionally abused me." "My lover left me." All these events can devastate a person. However, why is it that some people can move on from these events, while others avoid taking responsibility for their lives—sometimes for years after these events? Ultimately, if one is to live a life with purpose and meaning, one has to make good choices, despite these unfortunate, or even traumatic, events.
- **losing control:** Ever know someone who just "lost it" for a while? Whether they "lost their minds" and "went crazy" for a while, became enraged and lost their temper, or simply "lost their way" in life, these are mechanisms some will use to avoid taking responsibility for their current situation.
- **avoiding autonomy:** Some people know exactly what they need to do but don't do it. They feel too tired, too stuck, or too unwilling to move forward in their lives. Try to motivate these individuals, and they always have some reason for not moving ahead. This static existence is a way of avoiding making choices.

- **willing denial:** Numerous ways exist to deny oneself the possible choices that exist in one's life. One of the simplest is to deaden oneself to the world. For instance, if I numb myself to my existence, I am not allowing myself to be open to the possibilities that exist. I am willing myself into the denial of my experience. Or if I live in a fantasy world, I am not facing my choices. Instead, I am willing myself into a world in which reality and choices are askew.

  Jill is married to Jack. She does not want to be married to Jack. She is frightened to leave Jack. So she stays with Jack but imagines she is not married to him. Eventually she does not feel married to Jack. So she has to imagine she is. "I have to remind myself that he is my husband." (Laing, 1969, p. 47)

  Although individuals rarely experience themselves as being willing participants to these neurotic styles of living, existentialist therapists believe this is exactly what they are doing. Bringing consciousness to this kind of resistance is critical to the change process.
- **physical disease:** Although you would be hard-pressed to find a person who believes all diseases are self-created, there is enough evidence to suggest that many diseases are an outgrowth of the behaviors we manifest. Heart disease, some forms of cancer, colds from a lowered immune system due to stress, and many other illnesses have been shown to be related to the kinds of choices one makes (Golubic, 2013). Sometimes, having a disease may seem easier than taking responsibility for one's life.

Isolation

One can experience *isolation from others*, *isolation from self*, or *existential isolation* (Rubin & Lichtanski, 2015; van Deurzen & Kenward, 2005). Isolation from others is related to the aloneness one might feel if there is no one to relate to. Such isolation can be self-imposed (e.g., a monk taking a vow of silence or a neurotic person who's fearful of people) or other-imposed, such as when a person in a position of authority mandates isolation (e.g., a warden placing an inmate in "isolation" or a parent sending a child to their room).

Isolation from oneself occurs when a person ignores a part of self to the point that they are no longer aware of that part. To some degree, we have all done this, such as times when we may have ignored a particularly abusive remark. Some, however, deny major parts of themselves in an effort to separate themselves from a particularly painful event or trauma (e.g., sexual abuse). Such separation from oneself results in an inauthentic way of being, as the individual unconsciously avoids the part that has been denied. For instance, the child who was molested may deny their sexuality and then, when older, become incapable of enjoying sex. This part of self needs to be acknowledged and integrated into the individual's personality, which in this case would include the recovery of the painful memories that resulted in the original separation from self. Almost all theories of counseling acknowledge isolation from self, although most use terms like splitting, dissociation, or repression.

The last kind of isolation, existential isolation, is the realization that we are born alone, will die alone, and ultimately live in the world alone, although we will have important moments when we "encounter" others. Humans are expert at avoiding existential aloneness (e.g., constantly being on your cell phone) because to continually experience such isolation would undoubtedly prevent us from functioning in life. However, never facing or remaining unconscious of one's existential isolation has a price to pay—the development of unhealthy and destructive behaviors. The following actions are some ways that individuals avoid experiencing existential aloneness. Can you add others that you might use?

Overeating	Panicking
Under-eating	Obsessing
Over-drugging	Self-injury
Oversleeping	Angering
Over-sexing	Joking
Compulsing	Hating
Overthinking	Forgetting
Overplaying	Depressing
Fantasizing	Neuroticizing
Psychoticizing	Dissociating

Meaninglessness

> The deeper the experience of an absence of meaning—in other words, of absurdity—the more energetically meaning is sought. (Havel, 1990, p. 201)

Why do some people wholeheartedly give themselves over to a belief system, seek power, endlessly seek pleasure, or become obsessed with some inane work-related behavior? The existential therapists believe they attempting to avoid their *existential void*—often known as their *existential vacuum*—the awareness that existence is an absurd joke and meaningless. But if existence is meaningless, what is meaningful?

Unless we have given ourselves permission to step into the abyss of *meaninglessness*, we cannot know what is meaningful (Rubin & Lichtanski, 2015; van Deurzen, 2012). Taking this step is often profoundly threatening because it implies that we must first give up that which we have come to know. However, it can also be profoundly liberating. Initially, it means letting go of our values, faith, and beliefs and being once again the naked infant, willing to experience the absurdity of a world that has no meaning. Once we can touch this place within, we can reestablish contact with ourselves and begin to make new choices that will bring meaning and joy to our lives. And there is a kind of exhilaration we can experience in this knowledge—joy that we are in charge of our destiny. Ultimately, these choices may look eerily like how we were living before, but they are different because they have been chosen—not swallowed whole without reflection. It is only then that we understand the meaningfulness of existence and can take purposeful steps to making our lives meaningful (see Box 5.5 and Figure 5.4).

BOX 5.5 Some Thoughts About Meaninglessness and Meaningfulness

As you read the excerpt below on meaninglessness and meaningfulness, reflect on your own life, and consider how you avoid your existential vacuum:

I (Neukrug) sometimes wake up in the morning, look at my two beautiful daughters, and wonder: What purpose does any of this have? Why did their mother bear them, if ultimately, like me, they face their final demise? Death is at their doorstep, likely to first find me, then, soon, to find them. And why does any of this matter? I knew my parents and my grandparents. My great-grandparents I knew not. And what if I did? What if I knew them and their parents and their parents' parents? So what? Ultimately, they have taken up so little space in the billions upon billions of years the universe has existed and in the billions upon billions of planets that stretch out forever. Why would they matter at all? They are nothing, and they mean nothing in this vast expanse. Ultimately, I must ask myself, "How can I go on, knowing that I, my children, and all those who have come before me are an infinitesimal speck in time and space? What

mark will they leave, and what purpose do they serve? Ultimately, I am left realizing that I alone make meaning out of my life. And I also realize that every time I choose, I also affect the lives of my children, others close to me, and the world. There is a kind of exhilaration and joy with this knowledge—a freedom in knowing that I can choose my attitudes, my behaviors, and even my feelings as I go through life. I am the captain of my ship.

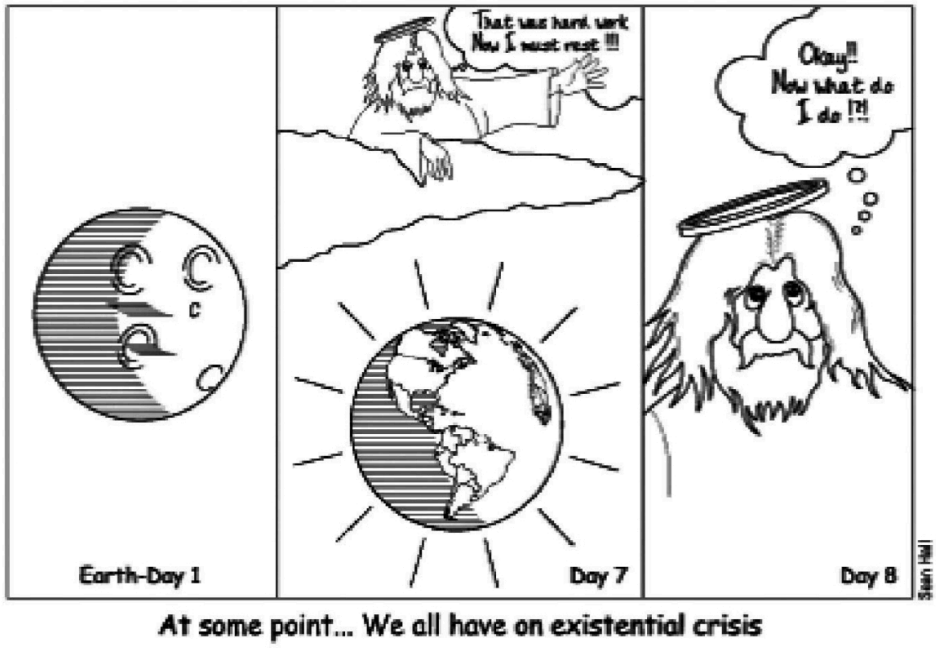

FIGURE 5.4 God Stepping Into His Existential Vacuum

Anxiety

Most existential therapists identify two types of anxiety: *existential anxiety* and *neurotic anxiety*. Existential anxiety (*angst*) is the anxiety that is experienced from one's realization of one's aloneness, the meaninglessness of life, and the knowledge of one's death. It is natural and normal to experience anxiety that results from our realization that we are ultimately alone, that we must be the ones to make our lives meaningful, and that we will have to face death. Neurotic anxiety occurs as a product of the mechanisms that are developed to avoid facing the essential existential issues of life and the existential anxiety associated with it. How these mechanisms are developed is not as critical as the fact that they are used to avoid an individual's angst. The mechanisms noted earlier to avoid responsibility (compulsivity, displacement, playing the victim, losing control, avoiding autonomy, willing denial, and physical disease) are generally used in the development of such neurotic anxiety.

Guilt

Existential therapists identify two types of guilt: *neurotic guilt*, sometimes called *moral guilt*, and *existential guilt* (Rubin & Lichtanski, 2015; van Deurzen & Kenward, 2005). Neurotic or moral guilt is

the remorseful feelings one has from having behaved in a manner that is damaging to the self or to others. Like the individual with a sexual addiction who continually goes back to his computer porn, the person with alcoholism who takes another drink, or the abusive lover who becomes enraged, these individuals have developed a set of neurotic behaviors that prevent them from reflecting on the meaning of their existence. These behaviors are the result of an internal split between how a person knows they should act and how they do act (see Box 5.6).

BOX 5.6 Moral or Neurotic Guilt

Note how the following behaviors may be damaging to self or to others. In addition, identify behaviors you might list for yourself that are damaging to you or to others. Do you feel moral or neurotic guilt as a result?

Behaviors	Damaging to Self?	Damaging to Others?
Addictive computer sex	_____	_____
Alcoholism	_____	_____
Verbally abusive behaviors	_____	_____
Other _____	_____	_____
Other _____	_____	_____
Other _____	_____	_____

In contrast, existential guilt is experienced when one gets beyond one's neurotic guilt to a deeper level of awareness—where there is a realization that one has not lived to one's fullest potential as a means to avoid dealing with core life issues and its associated existential anxiety. It is the guilt the abuser would have if they could realize the abuse was a mechanism of avoiding deeper reflection and a means of not making a more meaningful life. And it is the guilt an individual with computer sex addiction or alcoholism would feel if instead of sitting at the computer or taking a drink, they could quietly sit with self and reflect on how they have not made better choices in life. It is the guilt that clients can and should ultimately experience in therapy if they are courageous enough to embrace how they have avoided consciousness and, as a result, have made irresponsible choices (Hoffman, 2018; see Table 5.2).

TABLE 5.2. Major Differences Between Moral or Neurotic Guilt and Existential Guilt

Moral or Neurotic Guilt	Existential Guilt
1. Remorse for misdeeds or omissions	1. Free-floating and nonspecific
2. Caused by the discrepancy between our behavior and standards	2. A natural state of being that is the result of the difference between what we have achieved and our potential
3. Temporary and passes with time	3. Ongoing. One becomes increasingly conscious of this guilt with greater self-reflection and willingness to examine irresponsible behaviors.
4. Focused only on the area of the behavior that has caused remorse	4. Pervasive and possesses our entire being
5. We can relieve the tension by changing our behavior or standards.	5. We cannot overcome existential guilt; it is a natural part of our being.

Will to Meaning

> [Meaning is] the most fundamental and basic concern of man, neither pleasure nor happiness, nor power or prestige, but originally and basically his wish, his desire to find and fulfill a meaning in his life. ... then he's ready to suffer, he's ready to offer sacrifices, he's ready to undergo tension, stress and so forth, without any harm being done to his health ... but [if he has] no meaning in his visual field, then he takes his life. (Frankl, n.d., 0:50)

Frankl and other existential therapists believe that meaningfulness only comes with a deliberate effort on the part of the individual. This *will to meaning* is an active process that each person can choose upon realizing they have the power to define their own sense of purpose. And this will to meaning can only be developed after the individual has sorted through their neurotic lifestyle and neurotic guilt, faced their existential anxiety and existential guilt, and become increasingly aware of their true inner core. In contrast, the person who has chosen not to take this journey is forever participating in behaviors that are self-destructive and destructive to others.

Those who have the courage to face their sense of purpose and their existential existence can move forward toward meaningful existences. And even though a sense of purpose can evolve for such persons, meaningfulness does not bring with it ongoing happiness or the foregoing of existential anxiety because it is this very anxiety that fuels the search for meaning. However, it does bring a limited sense of freedom, momentary joy in the realization that the individual alone has decided their own destiny, and the humbling knowledge that each person alone is responsible for the choices they made and how those choices affect others.

Authenticity

Living with *authenticity* means acceptance of our existential existence, awareness of our death and nonbeing, and being willing to be honest with ourselves and open with others (Rubin & Lichtanski, 2015; van Deurzen, 2012). It means that we actively take responsibility for our lives as we consciously take steps toward meaningfulness. It also means that we intentionally avoid inauthenticity and the resulting neurotic anxiety and moral guilt. One of the goals of psychotherapy is to move the client from a life in which the individual used mechanisms to avoid taking responsibility toward a life in which, moment to moment, the client is open, honest, authentic, and real and makes responsible choices that positively impacts their life and the lives of others (see Figure 5.5 for a summary of key concepts).

Therapeutic Techniques

> ... [A]ttempts [to focus on specific skills of existential therapy] might only succeed in 'technologising' or 'operationalising' [its] practice, thereby limiting it to a rigid set of techniques, which in turn, severely contradict its aim of an immediate and open encounter between therapist and client. (Spinelli, 2015, p. 5)

The essence of existential therapy is the relationship between the therapist and the client, not the use of any specific techniques (van Deurzen & Adams, 2016). However, within this relational context, existential therapists tend to respond in certain ways to clients, and some will even apply what might be perceived as techniques. The following provides ways of being (i.e., techniques) with which most existential therapists approach the counseling relationship. These include using a dialectical method; educating the client about existential therapy; developing an authentic

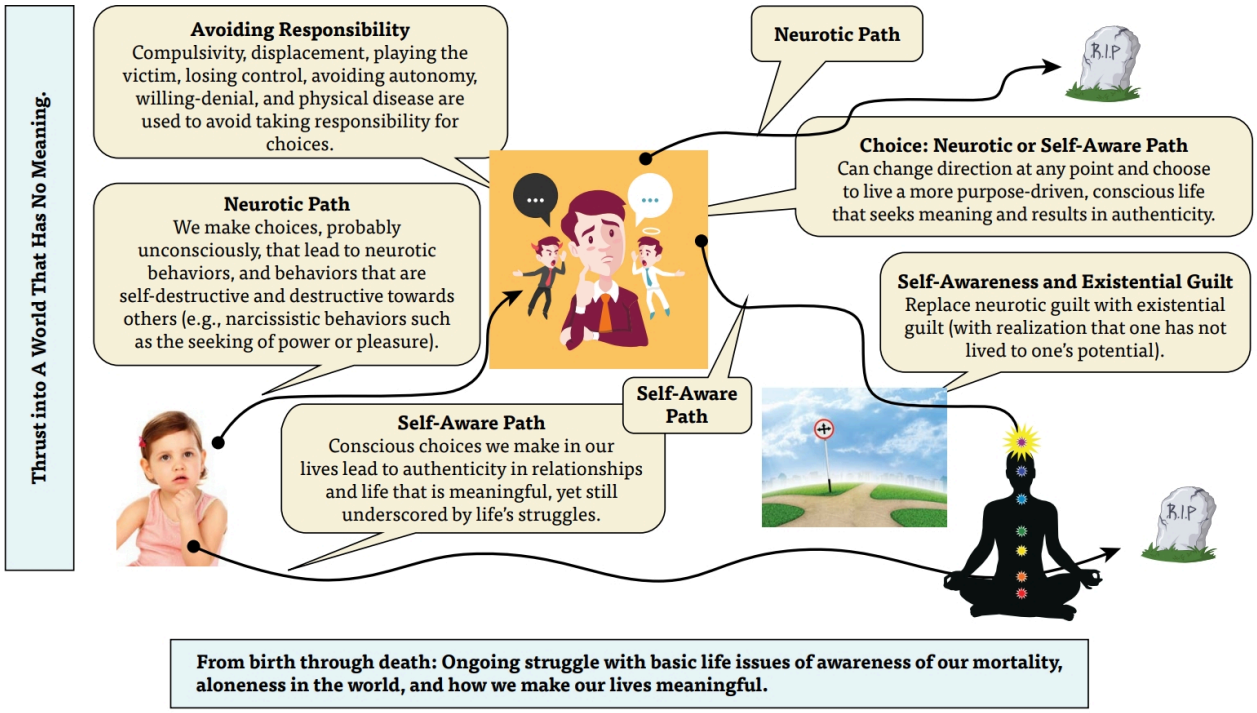

FIGURE 5.5 Key Concepts of Existential Therapy

relationship; applying a phenomenological perspective; showing acceptance; being confrontational; demonstrating encouragement; applying paradoxical intention; and encouraging dereflection when appropriate.

Dialectical Method

As with some of the other approaches in this text, the *dialectical method* of working with clients is core to building an effective and equal relationship between the client and the therapist. From an existential therapy perspective, this method of discussion and reasoning includes showing respect for the client, encouraging an open dialogue between the client and therapist, and providing an accepting atmosphere that allows for philosophical discourse about the meaning of life.

Education About Existential Therapy

In different ways, clients who attend existential therapy often receive *education about existential therapy*. Some counselors or psychotherapists may simply talk to their clients about the philosophy inherent in the approach, such as death and nonbeing, the origins of existential anxiety and existential guilt, the importance of finding meaning in life, our aloneness in the world, the power and responsibility we have to make choices that can better ourselves and others, and the importance of being authentic. Other existential therapists might encourage clients to read books, listen to songs, or watch movies that relate to this approach (e.g., books such as *Love's Executioner* by Yalom and *Man's Search for Meaning* by Frankl; songs such as "While My Guitar Gently Weeps" by Harrison and "Oh No" by Gogol Bordello; and movies such as *I Heart Huckabees* and *Groundhog Day*), and still others may choose to educate clients through modeling. Whatever educational approach therapists take, they have the same goal in mind—help the client learn about what it means to be human and to live the conscious life.

Authentic Therapeutic Relationships

> All actual life is encounter. (Buber, 1923/1970)

Key to helping a client understand themself is the therapist's ability to develop *authentic therapeutic relationships* that are similar to what Martin Buber (1923/1970) called the *I–Thou relationship*. Highlighted by a "give-and-take," free-flowing conversation that is devoid of façades and marked by authenticity and realness, such a relationship contrasts with an *I–It relationship*, wherein the client is objectified, as is the case with a therapist who diagnoses the client, is emotionally removed from the client, and uses techniques "on" the client. Clearly, a therapist who is willing to develop an I–Thou relationship cannot be afraid of being real with their clients.

Even though the counselor is authentic, open, and even self-disclosing at times, it is important to not confuse the I–Thou therapeutic relationship with one that a person might have with a close friend or lover. The therapeutic relationship is purposefully focused on the main counseling goal of helping the client learn about self. Thus, it would not make sense for the therapist to be overly self-disclosing or to engage in self-serving behaviors (e.g., becoming romantically involved with the client). Within this authentic therapeutic relationship, the therapist recognizes that therapeutic boundaries are necessary to foster the client's search for meaning.

Phenomenological Perspective

Using what's called a *phenomenological perspective* to gain a deep understanding of the client's subjective experience of the world, the therapist will *listen* intensely, show *empathy* to ensure deep understanding of the client, and ask questions to inquire about the client's perspective while being *nonjudgmental*. Some existential therapists believe it is important to understand four aspects of a client's world to understand the person fully (Binswanger, 1963; van Deurzen, 2012): *Umwelt* is how our biological organism (e.g., unique instincts, bodily functions, and senses) interacts with and is influenced by our environment and comes to understand the world (consider how lead in the water and climate change impacts each of us); *Mitwelt* is the manner in which the client comes to make sense of their interpersonal and social world, such as family, community, culture, society, and the therapeutic relationship itself; *Eigenwelt* is the way the client comes to understand their inner world, or psychological self; and *Uberwelt* is the manner in which we relate to the spiritual aspect of ourselves, or to the unknown.

Acceptance

As clients increasingly examine their worldviews, they will undoubtedly begin to challenge how they have been living their lives, feel moral and existential guilt, and become self-critical. Often, deeply embedded ways of behaving that have been harmful to self and others will be unearthed. At these junctures, it is critical that the therapist demonstrates *acceptance* and allows the client to continue to discuss their former ways of being as they begin to embark on a way of being in the world.

Confrontation

Confrontation can occur in many ways and, depending on the style of the existential therapist, the level of confrontation can vary dramatically. However, for most existential therapists, confrontation involves gently challenging the client about the kinds of choices they have made to bring purpose and meaningfulness in their life. Generally, this occurs using questions, such as the following:

- What aspects of your life do you feel good about?
- What aspects of your life do you feel bad about?

- Is what you are doing working for you?
- What kinds of behaviors have been helpful for you?
- What kinds of behaviors have been harmful to you?
- What brings you a sense of purpose and meaning in your life?
- How might you want to change your life?
- If you were to give up certain ways of being, what would you give up?
- If you were to adopt new ways of being in the world, how would that look?
- How do you avoid taking responsibility in your life for how you think, feel, and act?

Encouragement

Throughout the therapeutic process, clients are encouraged to self-reflect, consider the choices they have made, and work on the continual struggles of living. They are reminded that life is not trouble-free and that, although it sometimes seems easier to avoid life's difficulties than to face them head-on, ultimately, there is a price to pay for such an unconscious existence. *Encouragement*, such as by encouraging clients to examine how they are avoiding making meaning in their lives or by praising clients for squarely facing the struggles of life, helps them to continue their efforts toward taking purposeful steps toward meaningful change.

Paradoxical Intention

> Happiness must ensue. It cannot be pursued. It is the very pursuit of happiness that thwarts happiness. (Frankl, 1975, p. 85)

Paradoxes are strange phenomena. Sometimes, we seek happiness only to find misery, and when we find pleasure, it seems fleeting. Or some seek out power, then want more when they get it. Frankl understood the complexity and elusiveness of the paradox and, relative to satisfaction and meaningfulness, believed happiness to be a byproduct of living a meaningful life. Relative to symptoms, paradoxically, it often appears that when clients put a concerted effort into eliminating a symptom, it perseveres and even increases (Pattakos, 2008).

Thus, Frankl suggested using *paradoxical intention*—intentionally trying to make the symptom occur more often. Thus, the person who is germophobic and constantly washes their hands is told to wash their hands more. Or the person who is fearful of driving across a bridge is asked to drive across many bridges. Like what many therapists now call *prescribing the symptom*, for some unclear reason, prescribing the symptom seems to actually reduce its occurrence. This may be because the client suddenly realizes the absurdity of the symptom or that by doing it more, the client comes to see that they can control it. In either case, paradoxical intention seems to work in reducing or eliminating symptoms.

De-Reflection

All too often, we focus upon those aspects of our behaviors that prevent us from developing meaning and purpose in our lives, and sometimes, we end up exaggerating our symptoms because we have become so fixated on them. The depressed person becomes more depressed because they are depressed. The phobic person becomes more reclusive for fear of a panic attack. This never-ending cycle prevents the individual from examining core issues related to how one creates meaning in life and precludes the individual from experiencing the *existential void* that exists in us all. To prevent this kind of obsessive focus, *dereflection*, sometimes simply called *refocusing*, can assist the individual in developing a more meaningful existence (Pattakos, 2008). Frankl was particularly

adept at the use of dereflection in his own life, when, instead of focusing on his probable impending doom while in the concentration camps, he focused his attention toward the hope of seeing his wife again or toward finishing his book.

The Counseling Process

Explaining the therapeutic process of existential therapy reminds us of the movie Forrest Gump, when Bubba says there are "pineapple shrimp, lemon shrimp, coconut shrimp, pepper shrimp," and on and on. With existential therapy, there are so many ways of approaching the client that it's difficult to define a "one-size-fits-all" approach. After all, there are analytical existential therapists, humanistic existential therapists, Gestalt existential therapists, client-centered existential therapists, even rational emotive behavioral therapy (REBT) existential therapists, and so forth.

Given this situation, the following offers eight phases through which most existential therapists will pass as they work with their clients, although how they deliver this process can vary considerably. Table 5.3 provides recommended existential therapy techniques or relational skills by phase.

- **phase I—contact:** This is an initial *contact* phase, wherein the counselor and client meet one another, and there is an acknowledgement of different worldviews. Initial education about existential principles may begin at this point.
- **phase II—understanding:** In the *understanding* phase, there is an attempt by the existential therapist to clearly understand the worldview of the client.
- **phase III—education and integration:** The *education and integration* phase occurs when the existential therapist continues to educate the client about the existential worldview and dialogues with them about differences between their two worldviews. Sometimes, in this phase, the therapist gently challenges the client to embrace the therapist's alternate worldview that is based on the underlying philosophy of existential therapy.
- **phase IV—awareness:** Now that the client understands the basic philosophy of existential therapy, the client can begin the process of *awareness*, or becoming conscious of how they have avoided existential angst and guilt and have instead developed neurotic ways of living that have harmed self and others and are a direct result of not taking responsibility for the choices made in his or her life.
- **phase V—self-acceptance:** Awareness of how one has avoided existential angst and guilt eventually leads to *self-acceptance* of the kinds of harmful neurotic behaviors the client has embraced. The client now understands that, from this moment forward, they can choose differently. The client also realizes that "the unexamined life is not worth living" and that with self-reflection comes the ability to choose differently.
- **phase VI—responsibility:** Acceptance of the importance of an examined life brings with it the recognition that, from moment to moment, the client chooses their attitudes, thoughts, and behaviors. The client now realizes that neurotic behaviors are self-imposed and that they have *responsibility* for bringing meaning, dignity, love, and joy to his or her life.
- **phase VII—choice and freedom:** Realizing that we alone are responsible for our lives, the client can now begin to make conscious choices that free them from self-imposed neurotic constraints. The client now realizes that from moment to moment they have *choice and freedom* and can make meaningful decisions in their life. Like those in the concentration camps that Frankl noted had given up all hope of a meaningful existence, those who allow themselves to live in despair, figuratively or literally, die. In contrast, those who understand the choices they do have and the freedom that comes from choosing (with all the inherent struggles of living) will go on living and experience a sense of purpose (see Box 5.7).

- **phase VIII—separation:** As the client begins to live authentically and responsibly, they consciously choose those behaviors that will positively impact themself and others. At this point, the client initiates *separation*, wherein they no longer need the therapist and realize they can choose to be with, or separate from, other important people in their life as they constantly try to live a life with meaning and authenticity.

BOX 5.7 Live Free or Die

I don't want to achieve immortality through my work. I want to achieve it through not dying.

—Woody Allen

My (Neukrug) first job as a college professor was in New Hampshire. I'll never forget driving to "The Granite State" and suddenly seeing license plates with their slogan on them: "Live Free or Die." I immediately became excited, thinking I was moving to a state where the legislators all must live the examined life. How disappointed (and naïve) was I when I realized they were literal in their slogan!

Although many techniques can be used throughout the therapeutic process, it is more likely to see some exhibited more frequently in certain phases of therapy. Table 5.3 identifies which techniques are more likely to be used during the various phases.

TABLE 5.3. Techniques and Relational Skills by Existential Therapy Phase

Phase	Possible Techniques and Relational Skills
Contact	dialectical; acceptance; showing respect; encouraging philosophical discourse about the meaning of life; presenting and educating client about basic philosophical concepts of existential therapy; authenticity (give-and-take, no façades, sense of openness, realness, self-disclosure—all within boundaries of therapeutic relationship)
Understanding	phenomenological perspective; exploring client's Umwelt, Mitwelt, Eigenwelt, and Uberwelt; authenticity
Education and integration	continue educating about philosophy; confrontation: asking questions that focus on helping client examine self; encourage client to adopt new philosophy; authenticity
Awareness	empathy; acceptance; authenticity; encouragement
Self-acceptance	empathy; acceptance; authenticity; encouragement
Responsibility	dialectical; acceptance; authenticity; encouraging clients to take responsibility for the choices they make; paradoxical intention; dereflection
Choice and freedom	dialectical; empathy; acceptance; authenticity
Separation	dialectical; empathy; acceptance; authenticity

Social, Cultural, and Spiritual Issues

Since its beginning, existential therapy attended to the social and cultural world of the client (van Deurzen & Adams, 2016). For example, Binswanger and others highlighted the Mitwelt, or interpersonal and social world of the client, as one of four spheres critical to understanding the person. From the existential therapist's perspective, how the client makes sense of the world is partly a function of messages received relative to the client's ethnicity, cultural background, and sociological practices as well as the political atmosphere of the times (van Deurzen, 2012).

The role of the existential therapist is to understand the worldview of the client and ultimately help the client comprehend the inherent struggles that may be faced as a function of their Mitwelt (Hoffman & Cleare-Hoffman, 2011). As counselors come to increasingly understand their client's Mitwelt, they can use the dialectical method to discuss differences in worldviews between the two of them and increasingly move toward an I–Thou relationship (Spinelli, 2015). This type of relationship can facilitate a deeper understanding of each other and assist the client in finding more meaning. For instance, increased awareness of pervasive discrimination, sexism, and racism helps the client manage how to respond to such attitudes and behaviors.

Like other Western approaches to counseling and psychotherapy, however, existential therapy also has the potential to perpetuate Western dominant values that have traditionally served to marginalize culturally diverse clients (Hocoy, 2019). For example, a basic assumption of existential therapy is that of the autonomous self who can engage in self-actualization and free will (Valejos & Johnson, 2019). This individualistic orientation contradicts a group orientation found in collectivistic cultures where client goals center on benefits for the group, rather than the self (Hocoy, 2019; Wilson & Appel, 2013). In addition, although Frankl argued that any individual can achieve freedom by choosing one's attitudes (e.g., even in the concentration camps), there is little doubt that actual choices become limited and the ability to choose one's attitudes is particularly challenging when one is marginalized or experiences systemic barriers. Thus, since psychological growth is rooted in familial and social relationships, it is important for counselors to approach client self-exploration and decision-making considering these relationships and experiences of marginalization (Hocoy, 2019; Vallejos & Johnson, 2019). For example, for many diverse clients' loneliness and isolation due to marginalization is common and should be acknowledged and addressed through existential therapy (Ratanashevorn & Brown, 2021).

From an existential therapy perspective, a client's spiritual life is related to how a client finds meaning, defines their personal value system, establishes loving relationships, and gives to society (Spaeth, 2019; van Deurzen & Adams, 2016; van Deurzen & Kenward, 2005; Bretherton, 2006). So the Catholic, Jew, Protestant, Muslim, New Age adherent, and atheist all show their spiritual essence by how they have effectively reflected and acted in these areas. Ultimately, a self-reflective soul leads to the betterment of society because this individual is aware of the importance of choice in meaning-making and relationships and considers how each choice affects every other person. The nonreflective person, on the other hand, makes choices haphazardly and narcissistically. To enhance a client's spiritual life, the existential therapist helps the client increase their understanding of choice, meaning, and its impact on others and the world.

Attention to cultural competencies provides an opportunity to reexamine the relevance and application of existential therapy. Recommendations for existential therapy, from a cultural and diversity lens, include the following (Hocoy, 2019):

- Reflect on one's own cultural identity and how one's worldview about finding meaning may be culturally encapsulated;
- Gain knowledge about your client's cultural group memberships and how their worldview may impact whether the goals of existential therapy may be met;

- Reexamine theoretical constructs, assumptions, and values that undergird existential therapy, and consider whether they are congruent with client goals;
- Examine how cultural privilege and systemic oppression differentially impact how people make meaning and their eventual goals;
- Process with the client what they view as the "universal" and how such beliefs impact meaning-making and goal setting; and
- Engage in a conversation with a client about the constructs of existential therapy to determine if it is in sync with how they may view successful psychological growth.

Efficacy of Existential Therapy

Existential therapy emphasizes the processing of complex subjective experience of the client with goals including such elusive concepts as helping clients live consciously and choosing wisely, having clients recognize that life is filled with struggles, and assisting clients in finding what is personally meaningful (Vos, 2019). Such vague and nonspecific goals make it difficult to identify outcome measures to research (Hoffman et al., 2015; Vos, 2019; Vos et al., 2015).

> It is difficult to prove whether it is possible for clients, therapists, and researchers to discover true essences or know what fits best. This statement is not falsifiable. For example, can clients discover what is ultimately meaningful for them in life? Can clients ultimately know their best way of living? Or can we only pretend as if we know these matters? (Vos, 2019, p. 599)

Research in existential therapy becomes even more challenging because the manner in which the approach is delivered can vary considerably. This is not helped by the fact that many clients in existential therapy may replace one type of neurotic symptom with another, and "healthier" symptoms can look very much like neurotic symptoms, such as when neurotic anxiety and neurotic guilt are replaced by existential anxiety and existential guilt. Although existential therapists would see this replacement as "progress," measuring such changes would be nearly impossible (Walsh & McElwain, 2002).

As society faces complex challenges, such as pandemics, trauma, and disasters, clients will be struggling with their unique forms of existential guilt and existential anxiety, which become important areas to understand in both practice and research (Hoffman, 2021). Although qualitative research has examined the philosophical roots of existential therapy, quantitative studies are limited (Vos, 2015, 2019). Despite these challenges, there are some studies that can guide counselors' work. For instance, in a 9 of 15 randomized controlled treatment studies, Vos et al. (2015) found that existential therapy demonstrated significant and small improvements for psychological distress, self-efficacy, and client quality of life. Similarly, Stephenson and Hale (2020) found significant reductions in anxiety, stress, and psychological distress. In addition, Vos found that structured interventions (e.g., psychoeducation, exercises, and directly discussing meaning of life issues positively and directly with physically ill clients) seemed to be particularly beneficial for positive client outcomes. Furthermore, Barekati et al. (2017) found that existential group therapy was effective in reducing existential anxiety with older clients. Finally, Winter (2007) has identified studies that have shown positive outcomes for individuals with relationship issues, anxiety disorders, depressive disorders, anger-related problems, schizophrenia, severe personality disorders, trauma issues, and health problems.

In addition to quantitative research, there are countless qualitative studies that examine clients in their physical, social, personal, and spiritual worlds and how they directly experience these worlds (Vos, 2019). As counselors consider the effectiveness of existential therapy for addressing particular presenting issues (e.g., depression, anxiety, and career issues), they are encouraged to

review available qualitative studies related to those constructs. Although sample sizes in qualitative research tend to be small, reviewing multiple studies can provide important insight into clients' lived experiences of a particular phenomenon.

Although client outcomes are difficult to measure using this approach, examining whether existential therapy may be successful due to the way it is conducted has turned up some interesting results, including the following (Corbet & Milton, 2011; Craig et al., 2016; Duncan, 2014; Hoffman et al., 2015; Stephenson & Hale, 2020; Vallejos et al., 2015; Vos, 2018; Vos et al., 2015; Wampold, 2001; Wampold & Imel, 2015):

- The aspect of being authentic, open, and willing to examine self seems to be an important aspect of the change process.
- The therapeutic alliance has been consistently shown to be the most important feature of successful therapeutic outcomes. Such an alliance is strongly suggested through the I–Thou relationship.
- Empathy, one important skill and relationship variable in existential therapy, has consistently been shown to be a crucial element to successful outcomes in therapy.
- Existential therapy may show some efficacy for people coping with serious diseases, most likely due to its focus on meaningfulness and purpose.
- A focus on meaningfulness, worth, and value seems important to positive client outcomes.
- An existential therapy focus for individuals who have experienced trauma and disaster seems to have positive effects on client outcomes, especially when it is accompanied with cognitive-behavioral techniques.
- Existential therapy may decrease psychopathology and increase psychological well-being.

Although there is clear evidence that some aspects of existential therapy are likely to be helpful, research on the effectiveness of existential therapy has been limited, and more research that examines its efficacy should be completed (Duncan, 2014; Vos, 2018).

The Millers

The following shows Jake going through existential therapy. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Jake Meets an Existential Therapist

Standing on the front stoop Jake felt his world falling apart around him. As he grabbed the front doorknob, he flinched at the absolute quiet of the house. Once filled with the noise of Luke's antics and decorated with Celia's dolls and stuffed bears, the house now sat barren, silent, and empty. At work, Jake has been dragging himself around his office half-dazed since Angela took the kids to Philadelphia for the summer to stay with her sister. Angela had gone to help Lillian recover from hip surgery to address a congenital hip problem, but deep down Jake feared that Angela would not return. Mark, a colleague, had noticed Jake's distraction and lack of energy and had suggested he see someone about it. "I like this guy, Chris Landes. He was great when I needed to talk to someone about some problems my wife and I were going through. Maybe he could help you," Mark had offered. Jake realized he was ready to try anything.

"He looks awfully young," Jake thought to himself as he shook Chris's extended hand. "Nice to meet you, Mr. Landes."

"Hey, call me 'Chris.' Just take a seat anywhere," Chris offered, motioning Jake inside. Jake looked around the office, a hodgepodge of mismatched furniture, and watercolor landscapes that left him feeling vaguely uncomfortable. "You look kind of distraught, Jake. What's going on? Your message said something about your wife leaving?" Jake realized he was wearing the same rumpled shirt he was wearing when he fell asleep on the couch the night before and that he'd neglected to run a comb through his hair before leaving the house.

Jake, feeling somewhat unsure about Chris but also feeling out of options, took a deep breath and began, "I've been married 15 years; her name is Angela. We have two great kids, Luke and Celia. I love Angela a lot, and I think she loves me too, but for the last couple years we've been having problems. A lot of those problems were my fault; I was having some anxiety about the kids and even saw a counselor about it because the anxiety was bleeding out into my relationship with Angela. Even though I've worked on most of my anxiety, I think we still have a disconnect about the kids and how to keep them safe. There is so much at stake! I know. I've seen what can happen when kids make one foolish choice—it can affect their whole lives." Jake paused and then described the trauma of the accident with Justine and how the incident with Luke and Celia playing in the car had triggered renewed fears but also anger at Angela. "Angela should have been watching the kids! That never should have happened." Jake's voice rose and then fell again, "You know, it still makes me a little sick to think about Justine in her coma. I was pretty banged up myself, and my parents had to roll me in a wheelchair to see Justine; she was laying there with all those tubes and casts ... her body was black and blue. I realized that could have been me. It didn't make any sense that she was laying there practically dead, and I was going to be okay," Jake said, looking off into the distance as if he could see the whole scene playing out in front of his eyes. "You know, she never was the same; her whole life has just been a waste, no point, nothing."

"Jake, how have you made sense of what happened to Justine?" Chris asked.

"It doesn't make sense, at least none that I can see. She's like the walking dead. She doesn't have any real purpose, no one in her life, and nothing to do but put burgers on a bun, wrap them up and hand them to customers. All she cares about is making the perfect burger. She just goes on and on about those stupid burgers with a big, goofy smile on her face," Jake replied, his voice betraying a building anger. He clenched and unclenched his fist and looked out the window at the tall unkempt grass blowing gently in the breeze.

"I guess I see it a little differently," Chris began cautiously. "It seems to me that Justine has made something out of her life. It seems like she gets pleasure from doing her work and doing it well. You are also trying to make something out of your life. Your meaning comes from doing what you can to keep your family safe, but somehow that hasn't been satisfying to you; it seems that the harder you try, the more anxious you feel."

Chris Landes, taking an existentialist perspective, thinks of therapy as more or less unfolding in eight phases. Reflecting on his first meeting with Jake, he felt he made contact with Jake. Chris felt he made good progress in understanding how Jake experiences the world and made some first steps into education and integration—phases I, II, and III, respectively. Using an existential lens, he believed that by offering Jake his empathy and understanding, they would be able to build a strong therapeutic relationship, something he understood to be the essence of what makes existential therapy effective.

Chris noted that for Jake, the world is unpredictable and dangerous and requires his vigilant attention. On one level, Chris agrees with Jake: The world is full of unknowns, and it seems tragedy does seem to find its way into every life. Chris, however, believes that life's difficulties offer opportunities to make choices about how to respond. He believes that each of us has the choice to respond with courage and authenticity or to respond in fear and avoidance.

As Jake's therapy continued, Chris worked to educate him about the basics of the existential philosophy that underlies existential therapy. Chris offered some suggested readings, and Jake

promised to dust off his copy of *Man's Search for Meaning*. "I remember reading that when I was in college; it's still on my bookshelf," Jake remembered. In the weeks that followed, Chris continued to build the therapeutic relationship, hoping to create an I–Thou connection with Jake in which each of them could connect to one another authentically. As therapy moved into phase IV, awareness, Chris began to challenge Jake to see how his choices to avoid facing the existential angst inherent in living and his resistance to accepting that we are eventually going to die were, in fact, creating his panic. Chris hoped that Jake would understand that by avoiding the acknowledgment of the reality of death he had developed neurotic behaviors that had, in turn, driven a wedge between him and the rest of his family.

Borrowing a technique from solution-focused therapy that Chris believed fit nicely into the existential framework, Chris asked: "Jake, if you were to wake up in the morning and realized that something has happened as you slept—some change had come over you—as you opened your eyes, you realized you have adopted a whole new way of being in the world. ... What would that look like?"

"A whole new way of being—hmm, good question." Jake looked thoughtful for a moment. "Well, the first thing I think I'd do is make love to my wife. Instead of starting the day with my list of worries and nagging her about what to do and not do with the kids, I would just want to be there with her." Jake thought a moment and then said, "If I really had a whole new way of being, like you said, I think I would really be so different. I wouldn't be waiting for something terrible to happen or trying to devise ways to avoid disaster. I think the thing that would be most different would be that I would do something—just make a decision about something and do it. Maybe I'd take Luke up to the state park and go hiking; he's always asking me if we can do that."

As Chris continued to work with Jake, he hoped he would be able to help Jake understand and become accepting of how his avoidance of dealing with his "existential angst" had prevented him from living authentically, making choices in his relationships, and taking responsibility for his actions. Chris realized the importance of remaining empathetic to Jake's experiencing, while still challenging him to gain greater self-acceptance—phase V in Jake's progress toward meaning and change.

"So I guess one of the first things that would be different in life, if you had a whole new way of being in the world, would be that you would be closer to Angela and to your kids, especially Luke?" Chris asked.

"Yeah, that's right," Jake said, "I guess I can really see how my crazy need to keep everyone safe and close to me has driven my wife away. It is really hard to hear myself say that, but I think it's true. Angela didn't really have a choice; she had to get away. I think I was driving her up the wall!" Jake sighed deeply. "I guess there is an upside to all of this. At least now I know, now I understand, that I have some choice in how I deal with my fears and how I relate to Angela and the kids. If she comes back, I think I can turn this around."

"And if she doesn't?" Chris asked.

"Well, Chris, I don't know; maybe she won't. I would hate that, but you know, at least now I can go into whatever happens with my eyes open, knowing that I have choices about how I deal with our problems."

Chris realized Jake was moving into phase VI, responsibility, when Jake began the session by saying, "I've had a rough couple of days, Chris. You know, when we talked last week, I thought it was all coming together for me. I was thinking, 'Okay, yeah, I have choices here. I can decide how I want to be in the world. All I have to do is choose.' That felt pretty good, but then I started to think about what that meant."

Chris prompted Jake to go on. "You know," Jake continued, "I realized that if I have choices, well, then, it is up to me to do the choosing. That feels like a real burden. I mean, even if Angela does come back, I still have to depend on myself to decide what my life means and to shape it into something I can be proud of."

Chris, reflecting on his last session with Jake, noted that Jake had begun to think more deeply about the relationship between his choice to live in a world mastered by his anxiety or to master his anxiety by being more fully in a sometimes painful world. Together with Chris, Jake was able to explore what freedom meant to him and what kind of life he would like to build for himself. Chris noted that they had made the first steps into phase VII of their therapeutic journey: choice and freedom.

One afternoon, Jake came to the office excited: "Last Monday, I was lying in bed looking up at the blackness of the ceiling, and it felt like a weight pressing down on me. I started to feel myself getting more and more anxious about it when something you said several weeks ago popped into my head: 'Everyone dies sometime; there isn't really anything I or anyone else can do about it.'" Jake explained to Chris, "The strange thing was that, somehow, that was comforting. I realized that all the efforts I had put into trying to control something that can't be controlled had been a waste."

"Something seemed to change for you by really understanding that death is inevitable. So what sense have you made of that?" Chris asked, curious.

"Well, I decided to just get out of bed and to read some of that other book you suggested," Jake offered.

"You mean the Sartre?" Chris clarified. "Yeah, the Sartre. I had ordered it a couple of weeks ago but hadn't opened it yet. Anyway, I came across this passage where he said something like it is death that gives life meaning. That shifted everything in my head somehow. I was thinking that maybe that was true—maybe because we do die we have to make the most of every day."

"So you were caught up in those old familiar feelings of anxiety and thoughts about death when you decided at some level to take a turn, just try it a different way. Instead of getting more and more upset, you decided to get out of bed and read Sartre."

Jake nodded.

"I'm really impressed that you were able to make that shift, Jake," Chris beamed. Jake looked at Chris shyly. "So do you want to know what I did? Well, I took the rest of the week off of work, and I flew to Philadelphia. I know it sounds a little crazy, but when I got there, I rented a car and took Luke, Celia, and Lillian's two kids to a theme park a couple of hours away."

"That was spontaneous; you just had the feeling you needed to be with your family and went! What happened between you and Angela?" Chris asked. "She was surprised; I can tell you that! When Luke told her I took the kids on the roller-coasters, her jaw dropped open. After the kids were in bed, she and I went for a long walk. In some ways, it was like the old days. It was so nice to have her close to me again," Jake said, gazing out the window. "I told her I've been working on trying to be different in my life. I told her I was tired of being afraid to live." Jake paused. "You know, I felt completely different about myself, too. I had an excited feeling about being so spontaneous; that was new, but the feeling that really surprised me was the feeling I had about myself. I felt real and solid. I felt like I knew who I was and why I was in the world. I think before I always had this feeling that anxiety was holding me together, like I might break into really tiny pieces and get blown away in the slightest breeze. I don't feel that now. And one other thing—you know, I had this other funny thought also. I was thinking about going back to church. Not the same church I went to before but one where I could just go and find some inner solace and peace. Maybe someplace where I can reflect on my life and its meaning and God. I'm not sure where I'm going with this, but I know it's something I want to pursue."

In the following weeks, Jake and Chris moved into phase VIII of the therapeutic process: separation. Jake began to understand his values and began identifying the places from which he drew meaning for his life. Jake began to feel he was gaining clarity on the ways in which he tends to get sucked into avoiding meaning and the importance of being real, which made it possible for him to begin to take responsibility for how he will relate to others. When Jake was ready to end therapy with Chris, he admitted, "I'm still not sure how things will work out between Angela and

me, but I know that I can choose to continue to do things that drive her away from me and move me further and further from living the life I want to live, or I can be real with her and with myself. I can choose every morning when I step out of bed how I want to be in the world. ... I guess I do make that choice every morning!"

For You to Consider

1. Early in therapy, Chris explains to Jake the paradox of the world he lives in by saying, "It seems that the harder you try, the more anxious you feel." How does focusing on symptoms result in maintaining neurotic ways of being in the world?
2. In his work with Jake, how effective do you think it would have been if Chris had used "paradoxical intention" by asking them to try and be even more vigilant about assuring his and his family's safety?
3. In phase I of Jake's therapy, Chris broaches the topic of Justine's work and how that helps put a sense of meaning in her life. If you were Jake's existential therapist, how might you explore this further with Jake? Do you think Jake might be able to learn something from Justine?
4. In phase III, Chris begins to educate Jake about existential philosophy. How comfortable are you with teaching a philosophy to your client? What methods might you use to explain the basic tenets to your client?
5. How comfortable would you have felt if Chris decided to share some of his own struggles in life as an example of how life is often riddled with conflicts and struggles and as a mechanism to show how one has to constantly make choices in dealing with these difficulties? How comfortable would you be sharing some of your struggles in life with a client?
6. The chapter lists several ways in which people avoid taking responsibility in their lives, including compulsivity, displacement, playing the victim, losing control, avoiding autonomy, willing denial, and physical disease. Which of these methods has Jake used? Explain.
7. Do you think Jake would have been as motivated to change if Angela had not left for Philadelphia? What do you think the relationship is between external factors and the internal change process?
8. What do you think of Jake's possible newfound embracing of religion? Do you think he can be avoiding something through his religion? What possibilities lie in religious exploration for an I–Thou relationship? How do you believe his new faith experience will be different from how he once viewed faith?
9. Do you think Angela could benefit from existential therapy? In what ways has Angela been living inauthentically? What symptoms does Angela use to avoid her existential angst? How might you help Angela gain insight into the ways she has avoided making choices about how to be in the world?
10. How do you feel about making use of books, movies, poetry, and music to help clients gain access to their own meaning-making? How might talking about a book, a movie, or music in a session look? In what ways would this be different from talking about the same subjects with a friend? What types of questions might help your clients make connections between what is happening in a movie, a book, or music with what is happening in their own lives?
11. Of the following methods of avoiding responsibility in life, which do you use: compulsivity, displacement, playing the victim, losing control, avoiding autonomy, willing denial, and

physical disease? Are there other ways in which you may avoid living authentically in your own life? Explain.

12. What could you do differently that would bring authenticity into your life?

Summary

Existential therapy is a form of counseling based on philosophical assumptions of existentialism and phenomenology. Although Viktor Frankl was one of the first to pull together these philosophies into a therapeutic form, others also influenced its development, including Ludwig Binswanger, Irvin Yalom, and Rollo May. Frankl's biography was highlighted at the beginning of this chapter because his life, particularly the time he spent in the concentration camps, is particularly compelling and greatly impacted his theory.

The view of human nature of existential therapists includes many of the basic ideas from the existential and phenomenological philosophers who came before them. Thus, most existential therapists believe that people are not born bad or good but are simply thrust into this absurd world. They view meaning as self-created and that each of us is charged with the responsibility of making it meaningful through the choices we make.

Most existential therapists agree that the ability to face life's struggles is at least partially related to the kind of parenting that occurs. However, existential therapists do not see their role as unraveling repressed childhood memories. Instead, existential therapists believe that all people struggle with basic questions related to what it is to be human, such as the fact that we are born alone, will die alone, and, except for periodic moments when we encounter another person deeply, we live alone; that death constantly looms over us and reminds us of the relatively brief amount of time we have; that we alone are responsible for making our lives meaningful; and that meaningfulness, as well as a limited sense of freedom, comes through consciousness and the choices we make. However, they go on to note that many people live a life of limited self-reflection rather than authentically dealing with their existence. Such denial of one's existence can lead to feelings of anxiety, depression, and dread or living an inauthentic, neurotic, and maybe even psychotic existence. However, the approach is optimistic in the sense that existential therapists believe that through dialogue with others, individuals can gain a greater understanding of how their choices affect who they are and their impact upon others. Understanding is the first step to making new choices that can lead to a life that is more meaningful and purposeful.

Many humanistic approaches to counseling share much in common with the existential approaches, including the fact that they are antideterministic, believe in the power of choice in redefining who the person is, take a holistic perspective of the person, and are optimistic about the individual's ability to change. However, where the humanists believe there is a basic goodness to the person and that the therapist can facilitate clients in directing themselves toward becoming self-actualized, the existential therapist is more directive and educative, not quite as optimistic, and believes that the choices a person makes can help that person live an authentic life with all of its inherent problems, anxiety, and joy.

In understanding existential therapy, a number of key ideas and concepts stand out. These include phenomenology; death and nonbeing; freedom; responsibility and avoidance of responsibility, through such means as compulsivity, displacement, playing the victim, losing control, avoiding autonomy, willing denial, and physical disease; isolation (existential aloneness); meaninglessness; existential and neurotic anxiety; neurotic or moral guilt and existential guilt; will to meaning; and authenticity and inauthenticity.

The essence of existential therapy is the relationship between the therapist and the client, rather than the use of any specific techniques. However, within this context, some existential therapists embrace the following ways of working with clients: the dialectical method; educating

the client about the existential therapy philosophy; developing an authentic relationship; applying a phenomenological perspective by listening, showing empathy, being nonjudgmental, and inquiring; acceptance; confrontation; encouragement; paradoxical intention; and dereflection. The therapeutic relationship applies these relationship skills through what can be described as a series of eight phases that include contact, understanding, education and integration, awareness, self-acceptance, responsibility, choice and freedom, and separation.

Existential therapy has a long history of being sensitive to cross-cultural issues, especially in light of its historical focus on Mitwelt, or the social world, as one of the four client spheres important to focus upon. Such a focus helps the client understand how political, social, and cultural background affects the person and emphasizes the importance of how raising the client's awareness of these factors can impact the kinds of choices the client makes. However, despite this, there are some dominant Western values that drive existential therapy, such as the individualistic perspective of an autonomous self, which contradicts a collectivist focus of many marginalized clients. This can be partially overcome by ensuring that the counselor understands the client's world and has an honest sharing of worldview differences, which ultimately can lead to a sense of trust and mutual understanding. Relative to spiritual issues, existential therapists define spirituality broadly and include such things as religious beliefs, how one finds meaning, values held, the ability to love, and the way one gives to society. The role of the existential therapist relative to a client's spirituality is to help the client examine this part of his or her life and assist the client in becoming more conscious of the kinds of choices they have made relative to their spiritual life.

Finally, relative to the efficacy of existential therapy because existential therapy does not focus on symptom reduction and does examine several elusive concepts, it is difficult to measure client outcomes as compared to some other approaches. Despite this, some research has shown that at least some of the key elements of the process of existential therapy have been borne out by research, such as the importance of empathy, being authentic, and having a viable therapeutic alliance. More specifically, existential therapy has been shown possible positive results in helping people cope with disease, seems to be helpful when assisting clients in focusing on meaning in life and their sense of worth and value, is beneficial for those who are struggling with trauma, and has shown to decrease psychopathology and increase psychological well-being. And when lumped together with the humanistic therapies, it has also been shown to be helpful for relationship issues, anxiety disorders, depressive disorders, anger-related problems, schizophrenia, severe personality disorders, trauma issues, and health problems.

BOX 5.8 Want More?

You can hear stories about some of the leaders of the existential humanistic movement by going to the Stories of the Great Therapists website at http://www.odu.edu/sgt and clicking on Leaders of Humanistic Psychology.

Key Words and Terms

acceptance
angst
antideterministic
authentic therapeutic relationship
authenticity
avoiding autonomy
choices
collective guilt
compulsivity
confrontation
death and nonbeing
dereflection
developing an authentic therapeutic relationship
dialectical method
displacement
education about existential therapy
Eigenwelt
empathy
encouragement
existential anxiety
existential guilt
existential isolation
existential vacuum
existential void
freedom
I–It relationship
isolation from others

isolation from self
I–Thou relationship
listening
logotherapy
losing control
meaninglessness
Mitwelt
moral guilt
nonjudgmental
neurotic anxiety
neurotic guilt
optimistic
paradoxical intention
phase I—contact
phase II—understanding
phase III—education and integration
phase IV—awareness
phase V—self-acceptance
phase VII—choice and freedom
phase VIII—separation
phenomenological perspective
phenomenology
physical disease
playing the victim
prescribing the symptom
refocusing
responsibility
Steinhof Psychiatric Hospital
third wave of Viennese psychology
Uberwelt
Umwelt
will to meaning
willing denial

Key Names

Adler, Alfred
Binswanger, Ludwig
Buber, Martin
Bugental, James
Frankl, Elenore "Elly" Schwindt
Frankl, Elsa
Frankl, Gabriel
Frankl, Mathilde "Tilly" Grosser
Frankl, Stella
Frankl, Viktor
Frankl, Walter
Frankl-Veseley, Gabriele
Heidegger, Martin
Husserl, Edmund
Kierkegaard, Søren
May, Rollo
Nietzsche, Friedrick
Sartre, Jean-Paul
Tillich, Paul
Yalom, Irvin

CREDITS

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Gestalt Therapy

6

Learning Goals

At the conclusion of this chapter, readers will:

- gain a biographical understanding of Fritz Perls and the historical context in which he created Gestalt therapy
- understand the antideterministic, holistic, phenomenological, existentially based view of human nature upon which Gestalt therapy is based
- know key concepts that are the basis for the Gestalt approach, including holism, figure/ground, polarities, contact, the need satisfaction cycle, unfinished business, closure, and resistances or blockages to experience
- identify the commonly used techniques of empathy, being directive, being confrontational, avoiding intellectualizations, focusing on nonverbal behaviors, and being willing to experiment
- understand the specialized techniques of using now language, I–Thou communication, I–It language, experiencing the present, not gossiping, making statements out of questions, the dialogue game and empty chair technique, "I take responsibility for that," playing the projection, the exaggeration technique, feeding the client a sentence, "I have a secret," making the rounds, and dream work
- be able to articulate the structure of neurosis clients generally work through as they participate in Gestalt therapy: (a) the cliché layer, (b) the role-playing or phony layer, (c) the impasse layer, (d) the implosive layer, and (e) the explosive/authentic layer
- understand how the strong phenomenological perspective of Gestalt therapy lends itself to both supporters and critics of Gestalt therapy relative to cross-cultural issues
- reflect on whether Gestalt therapy's Eastern view of spirituality is adaptable to different religions
- have knowledge of the efficacy of Gestalt therapy in light of the many elusive concepts it proposes

In the second chapter in this section on existential-humanistic approaches, we discuss the life of theorist Fritz Perls and how his background shaped the development of Gestalt therapy. This chapter then presents the Gestalt view of human nature; key concepts of Gestalt therapy; major techniques; its therapeutic process; social, cultural, and spiritual considerations; and efficacy

research regarding the practice of Gestalt therapy. We conclude the chapter by applying Gestalt therapy principles to Angela, a member of the Miller family.

Fritz Perls

Fritz Perls wants us to live in the present and to live authentically. This he taught by example as well as in therapeutic sessions. Laura Perls, his estranged wife, once referred to him as half prophet and half bum. Perls felt the description accurate and used it himself, proudly. The prophet in him was fond of leading his psychological workshops in a reading of his Gestalt prayer:

> I do my thing, and you do your thing.
> I am not in this world to live up to your expectations
> And you are not in this world to live up to mine.
> You are you, and I am I,
> And if by chance we find each other, it's beautiful.
> If not, it can't be helped. (Shepard, 1975, p. 3)

Source: https://en.wikipedia.org/wiki/Gestalt_prayer.

Perls, the founder of *Gestalt therapy*, became an icon during the 1960s. As varying therapeutic modalities became increasingly popular, Perls offered something to his "followers" that others didn't: a sense that if you really "let it out," you would be free to be yourself. This fit in well with the "do your own thing" movement of the 1960s. A chain-smoker, overweight, and rude, he nevertheless became so popular that when he lay near death at a Chicago hospital, his friends asked the media not to let people know where he was for fear that the crowd would become overwhelming (Shepard, 1975). They found out anyway and led a vigil outside of the hospital. He died on March 8, 1970. But where did this guru of the 1960s have his start?

Fritz Perls was born to *Amelia Rund Perls* and *Nathan Perls* in the Jewish ghetto of Berlin on July 8, 1893 (Shepard, 1975). Despite moving out of the ghetto to a fashionable neighborhood in Berlin when Perls was only three, family life left much to be desired. Nathan, a philandering wine salesperson, could often be found in arguments with his wife over his absence from the home and suspected affairs. Amelia, angry at and bitter toward her husband, succeeded in causing Perls and his two older sisters to turn against their father. Apparently, for Perls, this was not difficult, as his father was authoritarian and stern and often referred to Perls as a *stück scheisse* ("piece of shit"). In fact, Perls's anger was so intense toward his father that it apparently led him to question whether he actually was his father, thinking until the day he died that his uncle may have been his actual biological father. Meanwhile, in addition to a chaotic homelife, there was rampant anti-Semitism in Germany at the time, and even though his parents tried to assimilate into German society, they had little success.

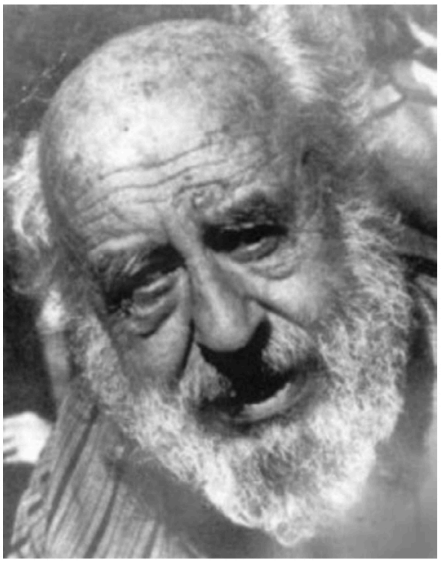

FIGURE 6.1 Fritz Perls

Perls's problems were not solely with his father. In fact, his mother would often hit him with whips and carpet beaters. It is interesting that, despite a clear lack of parental stability and trust, Perls described his childhood as a "happy one" (Shepard, 1975). This was at least partly due to his relationship with his sister *Grete*, who was one and a half years older and with whom he was particularly close. He and Grete

could often be found playing together, and Grete seemed to treat him like a younger "doll" baby, whom she loved dearly. This was in stark contrast to his relationship with his other sister, *Else*, who was three years older, legally blind, and described as unattractive and clingy to his mother. Perls feared that that he eventually would have to take care of her and even stated that he didn't mourn much when she died at a concentration camp.

At a relatively young age, Perls showed a streak of rebelliousness underscored by recklessness and maliciousness (Clarkson & Mackewn, 1993; Shephard, 1975). Probably originating from his parents' lack of a loving relationship, not having a stable male figure at home, the periodic violence he saw at home between his parents, and his mother's need to have him constantly sharing her vision that his father was no good, Perls often found himself in trouble. In fact, despite having been the top student in his elementary school, at the young age of 13 Perls was found stealing money from his parents, running away from home, causing problems at his new school, being truant from school, and engaging in early sexual experiences highlighted by a particularly demeaning experience with a prostitute. It is not surprising that Perls was eventually thrown out of his high school.

Eventually, finding another high school that offered a more humanistic approach to teaching adolescents, Perls began to settle down. This school, with its positive approach to children, was in stark contrast to the authoritarian approach of most German schools and was to be a second home for Perls. During this time, he also stumbled across a theater group and became immensely interested in acting. His work in the theater allowed him to make some money and redirect his excess energy, and his experience in the theater was also foundational for many of the techniques he would eventually create that had a bit of the theatrical in them.

The varied and often negative early experiences of Perls, says biographer Shepard (1975), were at least partially responsible for the adult Perls having a lifelong difficulty sustaining a relationship, having a strong need to be affirmed, being obsessed with female genitalia and with sex in general, and being outspoken. Shepard also hypothesized that these difficult childhood experiences may have been a primary force that led Perls to encourage experiencing the "here and now" and to discourage long, analytical examinations of the past—a past that in Perls' case would have dredged up a great deal of pain.

As World War I loomed over the horizon, Perls entered medical school, a natural fit for his abilities. However, with the war beginning, he volunteered with the Red Cross and, later, knowing he was to be drafted, enlisted in the German army (Resnick, 2015a). His involvement in World War I and the atrocities he saw resulted in his somewhat pessimistic view of the world, while also making him passionate about trying to advocate for a more humanitarian world.

The 1920s were a decade of change for Perls. Attaining his medical degree and practicing as a neuropsychiatrist, Perls "concentrated on prescribing medical cures for a variety of psychological and neurological complaints" (Shepard, 1975, p. 29). Still living with his mother and his blind sister, Else, Perls had a poor self-image and thought of himself as physically and sexually inferior. Increasingly, he began to spend time with the bohemians of the era: artists, poets, writers, and philosophers, who were considered part of the counterculture of the time. It was at about this time that he befriended *Sigmund Friedlander*, a philosopher who forwarded the idea that opposites define the individual and that we all seek a *zero point*, or the point that brings us to closure or homeostasis. When an organism expresses too much of one attribute, it becomes necessary for it to compensate by bringing in the opposite attribute to restore equilibrium. Perls's friendship with Friedlander would greatly mold his view of the world and his eventual theory.

After a relatively brief but unfulfilling trip to America exploring possible work opportunities, Perls returned to Germany and would soon meet a distant relative, "*Lucy*" (Shephard, 1975). Perls was enamored by Lucy, and she showed him a new world as they explored the outer limits of their sexuality, even by today's standards. This charged relationship would "awaken" Perls but also cause him intense internal struggles, as he attempted to manage all these newfound intense feelings.

Thus, he entered psychoanalytic treatment with the well-known analyst *Karen Horney* (Resnick, 2015a). This foray into analysis became the impetus for Perls to become an analyst himself and eventually develop his own theory.

Analysis resulted in him breaking up with Lucy and moving to Frankfurt, where many well-known existentialists like *Martin Buber* and *Paul Tillich* talked about and published their ideas (Resnick, 2015a). In addition, it was here that *Kurt Goldstein*, who was doing research on brain injury, proposed new hypotheses about how individuals perceive the world, which he called *Gestalt psychology*. Although a far cry from what would eventually become Gestalt therapy, Perls did borrow the name from this group. In Frankfurt Perls met *Lore "Laura" Posner*, whom he would eventually wed. Despite being much younger than Perls, as a graduate student of Gestalt psychology and having studied many of the famous existentialists and phenomenologists, she would eventually influence many of Perls's ideas (Clarkson & Mackewn, 1993). However, coming from a refined family that found Perls somewhat of a bohemian, her parents initially discouraged their relationship. Despite her family's misgivings, they married in 1929.

Meanwhile, Perls continued to undergo his own analysis and eventually started to practice psychoanalysis under supervision, which helped him coalesce his ideas on how instincts impact the person, the meanings that dreams bring, the power of the unconscious, and the importance of what he called *shouldisms* in his life. Shouldism, in analytic terms, was related to the moralistic superego and would later become an important part of Perls's concept of *topdog*, wherein he believed a part of the self splits off and tries to take charge of other parts of the self. However, despite years of his own involvement in psychoanalysis, Perls never really felt comfortable with this approach. Looking for something "more," Perls eventually found *Wilhelm Reich*, who was considered a radical psychoanalyst at the time. Reich taught Perls about *body armor*, or the process in which the body holds in feelings. This would greatly affect Perls's ideas about the importance of focusing on nonverbal behaviors in therapy.

During the early 1930s, Perls became involved with the anti-Nazi movement in Germany (Resnick, 2015a). However, increasing anti-Semitism would leave Perls, his wife, and their new baby in desperate straits, and after several moves, Perls and his family eventually ended up in South Africa. Here, he and Laura quickly established the country's first psychoanalytic training institute, and the couple thrived monetarily but not emotionally. The couple had two children, *Renate* and *Steve*, but Perls clearly was only involved with the children in a cursory way, and his wandering eye left little passion for the marriage. Meanwhile, fascinated by the book *Holism and Evolution* (Smuts, 1926), which was written by the then prime minister of South Africa, Perls began to incorporate holistic concepts into his own theory. Excited about his new ideas and how they might affect analytical therapy, Perls went to Europe to present them to Freud and others at a psychoanalytic conference. After quickly being dismissed for his radical ideas, and perhaps out of spite, he pressed forward and developed his own theory.

The early 1940s saw Perls publish his first book on his theory: *Ego, Hunger, and Aggression* (Perls, 1942/1947). Challenging many of Freud's assumptions, this book also asserted many of Perls's new ideas, such as (a) the importance of hunger as a motivating force, while de-emphasizing the sex drive; (b) the notion that the present carries unresolved conflicts and spending endless amounts of time dredging up the past is largely a waste of time; (c) the importance of polarities, or different parts of self, in understanding the person; (d) how the body takes in and manifests experiences; (e) a de-emphasis on transference because it focuses on the early origins of experiences rather than the "now" of experience; and (f) the importance of creating a real relationship between therapist and client to break down delusions and myths that clients have about their therapists (in contrast to the "anonymity" in psychoanalysis).

To support the war effort against the Nazis during World War II, Perls joined the English army as a medical officer. When the war ended, he became increasingly disgusted by the growing

discrimination against the South African Blacks and left South Africa for New York City. With the help of neo-Freudians, like *Erich Fromm*, Perls established a practice that attempted to bridge the gap between the therapist and the person. This led to Perls being blatantly honest with people as well as increased sexual experimentation that ran the gamut from heterosexuality to bisexuality to homosexuality. In fact, Perls even challenged the taboo of having sexual encounters with clients, as he attempted to break the walls down between the client and patient. Clearly, in today's world, Perls would have quickly lost his license.

As Perls increasingly settled into his own theory, he incorporated concepts from other ideas and philosophies, such as *psychodrama* (Clarkson, 2013, Conyne, 2015). Developed by *Jacob Moreno*, this approach had a client in a group setting describe their family dynamics and then had group participants role-play various family members. Psychodrama influenced Perls's ideas about the importance of role-playing aspects of oneself, others, and parts of one's dreams during a session. Around the same time, Perls began to show some interest in *Eastern philosophy*, especially *Zen Buddhism* and its concept of *mindfulness*, which, to Perls, seemed similar to the importance he placed on awareness of the now (Clarkson & Mackewn, 1993). Perls was also greatly influenced by *Paul Goodman's* ideas about the importance of breaking down traditional social mores and psychological assumptions if a person is to truly reinvent oneself and establish a new kind of extended community (Resnick, 2015a). In fact, Perls, Goodman, and *Ralph Hefferline* would soon write *Gestalt Therapy*, one of the first definitive books on Perls' theory (Perls et al., 1951). Soon after the book was published, he and Laura opened the *Gestalt Institute of New York*.

Although the institute did well, he and Laura were in an emotional tailspin (Resnick, 2015a; Shephard, 1975). No longer could Laura accept her husband's continued absence and sexual exploits with others, and in the late 1950s, they separated. Now in his mid-60s and having health problems, Perls left for the better weather in Miami to open a new practice, where he met a 32-year-old client named *Marty Fromm*. The two became involved and, over the next few years, had a relationship of "realness," in which they would be blatantly honest with one another, participate in sexual experimentation, and use "mind-expanding" drugs, such as LSD. Meanwhile, Perls continued to see Marty in both individual and group counseling. Soon, Marty began to date Peter, another of Perls's clients, and, at this point, Perls decided to leave for California and asked Marty to choose between him and Peter. Marty stayed with the much younger and more attractive Peter.

Perls had been offered a position as a long-term consultant to psychiatry residents at *Mendocino State Hospital*, and in some ways, his move to California was probably a relief from the intensity of his relationship with Marty (Clarkson & Mackewn, 1993). Although the drug scene had not fully erupted in California, it had for Perls, and he was taking LSD almost daily. Despite his drug use, health problems, and ongoing narcissistic tendencies, which often led to brazen conflicts, he appeared to manage himself fairly well. By this time, his reputation preceded him, with some viewing him as an aging narcissist, while others saw him as a seductive guru. As the 1960s rolled in, an increasing number of humanistically oriented therapies became more popular. The *Esalen Institute*, a retreat house on the coast of California, soon became known for its humanistically based workshops. Perls, whose theory had become increasingly existentially/humanistically based, would soon find a home here (Resnick, 2015a). In fact, in many ways, the Esalen Institute became another Gestalt Institute. Eventually, Perls moved into Esalen, where he spent most of his remaining years, although the last year of his life he spent developing the *Gestalt Institute of Canada*. At the Canadian institute, Perls is said to have finally found some inner peace. In 1969, some of Perls's recorded work with clients was edited and published in the book *Gestalt Therapy Verbatim* (Perls, 1969a). Also in this year, the book *In and Out of the Garbage Pail* was published, which offered a particularly candid view of Perls's opinion of himself and others through his writing, poetry, and prose (Perls, 1969b).

Although Perls struggled with ongoing health problems, including heart irregularities, he nevertheless traveled much and conducted workshops. In 1970, while in Chicago to conduct one

of his workshops, Perls became seriously ill with a high fever. While at the hospital, he reached out to Laura, who was in New York, and she came to his bedside. After exploratory abdominal surgery, Perls, as rambunctious as ever, had the following encounter with a nurse:

> At about nine o'clock that evening, he kind of half got up with all this paraphernalia attached. The nurse said, "Dr. Perls. You'll have to lie down." He sort of went back down and then almost sat up and swung his legs out a bit. Again she said, "You must lie down." He looked her right in the eye and he said, "Don't tell me what do," fell back, and died. (Shepard, 1975, p. 192)

There is little question that Perls lived like he died: narcissistic, rambunctious, and honest to the end. And although today's Gestalt therapists have many more boundaries than Perls had, the essence of his theory and the many techniques conceived by him remain true to Perls's original ideas (see Box 6.1).

BOX 6.1 Want to Meet Fritz Perls?

Want to hear a brief biography about Perls from the man himself and find other tidbits of information about him? Go to https://silver.odu.edu/psyadm/ to see a caricature of Perls talking about himself and his theory. Click on the existential-humanistic door, and go into Perls's office.

View of Human Nature

Perls believed that the infant is born neither good nor bad and with a capacity to embody an infinite number of personality dimensions (Perls, 1978). He suggested that these dimensions come in pairs, each comprised of *polar opposites*. Where there is good, there is bad; the extrovert has an introverted side; and the cold, distant person has a loving side. He also suggested that if one aspect of the person is being expressed, its opposite is hiding somewhere, and if it is not expressed, the body is taking up energy trying to keep it out of awareness.

Grounded in the humanistic tradition of *existentialism* and *phenomenology* (Resnick, 2015b), Gestalt therapy posits that reality is based on each person's experience and that an individual can make choices throughout life that can result in creating a new way of being in the world—a new reality. The humanistic tradition is also steeped in *holism*. Thus, Perls, like many other humanistic psychologists, did not believe in the reductionistic theories of Freud, who dissected the person into the id, ego, and superego or the micro lens of the experimental psychologists, who attempted to understand the individual relative to isolated aspects of behavior. Instead, he argued that the mind, body, and soul operate in unison; they cannot be separated. The evolving self is the result of how the whole being reacts to familial, social, and cultural influences. This is why Perls borrowed the term *gestalt* from the Gestalt psychologists, which means the properties of the whole are always different and more than the sum of its parts. Most likely, Perls would view today's modern-day cognitive and behavioral therapists as blasphemous in their attempts to focus on minute aspects of behavior or cognitions.

Most Gestalt therapists believe that from the moment one is born, the individual is in a constant state of self-regulation through processes of *need identification* and *need fulfillment* (Conyne, 2015; Perls, 1978). Some of the innumerable examples of this include the newborn infant who seeks to suckle the breast, the playful child who seeks attention, the budding adolescent who seeks out peer relationships, and the adult who seeks out work and life fulfillment. An individual's pressing need dictates their perceptual field (what the person sees) or, as Gestalt therapists state, the need that is in the *foreground*. Imagine watching a movie about your life. With some exceptions for "rest," each frame of the movie is reflective of a specific need that you are somehow trying to fulfill at that moment in your life. Because needs can vary dramatically, this theory contrasts with the psychoanalytic view, which suggests that a limited number of instincts drive behavior (e.g., hunger, thirst, survival, sex, and aggression) or the Maslowian (humanistic) idea that basic

needs (e.g., hunger and thirst) are addressed prior to higher-order needs (e.g., love, belonging, and self-esteem).

> You can believe in two instincts ... or you can believe in two million instincts, or unfinished situations, like I like to do. I believe that our organism is so complicated, that every time something happens to it, is experienced by it, we are thrown out of balance and at each moment we have to regain this balance. (Perls, 1978, p. 58)

For the Gestalt therapist, how the individual contacts their environment to satisfy needs is reflective of the individual's way of being in the world and determines the *self* (Perls et al., 1951; Polster & Polster, 1973). The healthy individual has a semipermeable boundary that allows the individual to maintain a sense of self, while also allowing material from the environment to be engulfed, "chewed," and taken in as it becomes assimilated (Yonteff, 1976). This person has a constant free-flowing exchange between self and "other" (all that is outside of self), and this exchange causes the self to be constantly changing; as needs are met, the self changes. In fact, Perls viewed the changing self as synonymous with what he called the *ego boundary*; that is, as the self interacts with the environment and changes, so does the boundary that identifies who the person is and how the person sees themself (Perls, 1969a). For instance, when "falling in love," the boundary extends out and includes the essence of the other person. At that moment, the person's sense of self, indeed the person's ego, has changed.

Satisfaction of needs is a natural process, and Gestalt therapists believe that individuals are driven to have their needs completed or finished (Conyne, 2015). However, needs can be thwarted by parental shoulds, social and cultural dictates, and peer norms that influence the development of mechanisms that resist the experience of a pressing need. These mechanisms yield individuals who are fake, incongruent, false to their nature, and "playing" at being a self-created image, all to avoid the experience of the need. Such false behaviors result in *impasses* or *blockages* that prevent experiencing and are revealed through dysfunctional and neurotic behaviors, which are called *unfinished business* by Gestalt therapists.

Because Gestalt theorists believe we can choose to experience ourselves fully and free ourselves from our impasses and blockages, the Gestalt approach is considered *antideterministic*. In contrast with traditional psychoanalysts, who view defense mechanisms as important to maintaining the integrity of the ego, Gestalt and related therapies believe that sanity is allowing one to fully experience the present by breaking down defenses that are the result of one's impasses, blockages, and resulting unfinished business (Hart et al., 1975). Since experiencing fully is the basis for seeing reality clearly, Perls famously stated that: "To me, nothing exists except the now. *Now = experience* = awareness = reality. The past is no more and the future not yet. Only the now exists" [emphasis added] (Perls, 1970, p. 14).

> We feel that each person who is not completely feeling himself and sharing that level of feeling with those around him is reasonably insane. (p. 120) ... Craziness or disorder allows a person to put up with almost anything—that was the original function of each disorder. But a sane person values his feelings and does not want even one moment of disorder to engulf him. (p. 375)

Using a variety of techniques that help access all their current feelings, thoughts, and experiences, clients increasingly experience the "now" and can quickly identify and understand their blockages, impasses, and resulting unfinished business. After specific unfinished business is worked through, it leaves the foreground and allows room for new issues to arise. This process is akin to the peeling-of-an-onion metaphor: "We can open one door at a time and peel off one layer of the onion at a time. Each layer is part of the neurosis" (Perls, 1973, p. 84). For instance, a client who is angry at her spouse may avoid her rage by eating too much (stuffing down feelings), working an

extreme amount, staying away from home, extensively playing with her children, and so forth. As the therapist works toward helping the client experience her anger, she is likely to begin to have associations as to why she has avoided her anger (her unfinished business). For example, she may be avoiding anger, because her parents told her that anger is not "ladylike." For her, "acting ladylike" (or, as Perls liked to say—being a "phony") has superseded the way she actually feels. By pushing the client to experience her anger, she ends up examining issues from the past, which deeply affect the way she makes choices in the present (Polster & Polster, 1999). In this sense, there is a kind of seamlessness between present, past, and future.

Developmentally, Gestalt therapists believe that people move from *environmental support* to *self-support* as they grow (Wollants, 2012). Thus, the young child relies on others to survive and feel whole. However, as the child grows, they increasingly rely on self to find ways of meeting their needs. Healthy people have learned how to be self-supportive, although not socially isolated, for relationships are basic to existence. Unhealthy people rely on others for their sense of self and, when things go wrong, will tend to blame others because they do not see themselves as separate from others. And like the spouse who evaded her anger, such individuals do not take ownership of their feelings. One can see why, for Gestalt therapists, examining whether a client is taking *responsibility* for their feelings and experiences is critical.

As you might guess from the view of human nature, the goal of Gestalt therapy is to help the client move from a state of little awareness of self, an inability to effectively respond to needs, and difficulty in taking responsibility to a healthy state, wherein the individual is aware of their needs, is able to seamlessly respond to them in the moment, and can take responsibility for feelings, thoughts, and actions (Resnick, 2015b). Table 6.1 compares some of the qualities of the healthy and unhealthy person based on this understanding of the person.

TABLE 6.1. Gestalt View of the Healthy and Unhealthy Person

Healthy Person	Unhealthy Person
• Able to experience the "now" • Has clear perceptions about what needs are pressing and can differentiate those needs from all else that is in the background • Has clarity of bodily sensations and how they are related to the pressing needs in the moment • Able to experience, state, and deal with needs as they arise; allows for the need with the next-highest demand to be addressed • Has a sense of openness and realness • Body language is congruent with how the individual responds to the world • Self-supportive and able to take responsibility for self and actions • Has a sense of how one's actions affect others and the world • Accepts and integrates all aspects of self, including polar opposites • Accepts others in the world with their unique ways of understanding human nature • Able to accept differences	• Unable to experience the present • Unable to distinguish what needs are pressing on the person; confused about what is foreground and background • Out of touch with bodily sensations that signal need-fulfillment. • Unable to experience, express, and, subsequently, address needs. • Closed off, fake, and phony • Body language does not match feelings and experiences • Uses environmental support and does not take responsibility for self and actions • Incapable of seeing how self affects others; selfish and narcissistic • Denies aspects of self, particularly those that are seen as "bad" or "evil" • Has a desire to have others see the world in the same manner they see the world • Unable to accept differences

Key Concepts

Some of the key concepts that are the underpinnings of gestalt therapy include *holism*, *figure/ground*, *polarities*, *contact*, *the need satisfaction cycle*, *unfinished business*, *closure*, and *resistances* or *blockages to experience*.

Holism

> All the parts of a car laid out on the ground give you many metal, rubber, ceramic, liquid, and plastic bits and pieces. However, organize them in a very particular relationship to one another and you have a car in which you can now drive away—certainly different from and, in this instance, more than the sum of its parts. Organize them randomly and you have an art project—or a pile of junk. (Resnick, 2015b, p. 458)

Although many humanistic psychologists have spoken about *holism*, Perls, more than most, highlighted holism as central to his theory (Bowman, 2012). From Perls's point of view, holism means that all aspects of the individual, both internally and externally, are connected. Thus, the spiritual, mental, physiological, and psychological parts of the person are inseparable and connected to external forces, such as family, community, and the world. There is no split between the body and the mind, as so many modern-day therapists continue to suggest. Thus, when a person is hungry, they experience the hunger, think about the hunger, have a bodily reaction to the hunger, and respond emotionally to the hunger. And perhaps, the hunger of one person reverberates with those around them, in the community, and in the world. And in contrast to the causal thinking that has invaded the way many therapists conceptualize clients, Perls suggested that all parts of the person respond in unison. So it is not irrational thoughts that cause negative consequences, or specific reinforcement contingencies that lead to dysfunctional behaviors, or the id that is impinging on the ego. Therapists who think in this manner are artificially creating a wall between separate parts of the self, say Gestalt therapists.

Figure/Ground

Drawing from the school of *Gestalt psychology*, Perls molded part of his theory around the concept of *figure/ground*, which suggested that we perceive what is in the foreground of experience and tend not to recognize what is in the background (Clarkson, 2013; Conyne, 2015). Perls also noticed that one can learn how to "switch" or "flip" one's experience. For instance, in Figure 6.2, one can eventually learn to discern fish or birds if one concentrates solely on form. Perls extended this understanding to other kinds of human experience, stressing that when a need emerges, it takes precedence over other needs and moves into the foreground. As that need becomes satisfied, it will move into the background, and a new need will emerge. Perls went on to say that some needs become blocked and result in *unfinished business* in the sense that a blocked need prevents the individual from fully experiencing and results in individuals living phony lives.

Polarities

Closely related to the concept of figure/ground are Perls's thoughts on *polarities*. Believing that we have an infinite number of polarities, Perls suggested that dimensions of the self come in pairs or opposites (Mann, 2020; Polster & Polster, 1973, 1999), and he suggested that those parts of self with which we feel comfortable are acknowledged, or in the foreground of experience, while the opposite part hides away, are out of awareness, and are in the background of experience. Denying

FIGURE 6.2 Den Haag Relief Houtrustweg

one's hidden part is an unnecessary expenditure of pent-up energy, say the Gestaltists. Thus, one goal of therapy is to reach the hidden parts of self and to integrate those parts into one's personality style. Consider the implications this has for the "loving and nurturing" person who denies their devilish playful side or the "evil" sociopath who denies their empathy and goodness. From this perspective, you can see why Perls viewed people as neither good nor bad—they embody it all.

One pair of opposites that Perls popularized was the topdog–underdog polarity. The *topdog*, said Perls, is the part of self that is bossy and the "master," while the *underdog* is passive, slave-like, and inept. Perls would often have clients play out these two distinct aspects of self to show clients how one aspect has taken over and has created an imbalance within the self as well as in the client's interpersonal relationships. A balance between these two polarities more fully represents the person and will lead to increased honesty and satisfaction in relationships.

Contact

Contact defines the boundary between the self and other, whether it be an object or a person. It is our lifeblood and how we make contact determines how healthy we are (Clarkson, 2013; Mann, 2020; Sills et al., 2012). Contact with an object generally involves our sensory organs (e.g., I'm hungry; I touch some food and pick it up and eat it). With people, contact is a function of the ability to experience the other fully. It is, as Martin Buber (1958) noted, related to the *I–Thou relationship*.

Contact is directly related to what Perls called our *ego boundary*, or the constantly changing point where I "meet" other people and objects and discriminate me from "other" (Polster & Polster, 1973). Meeting the "other" and experiencing little difference between oneself and the other is called *confluence*. Contact disturbances occur when I must have "you" in "me" all the time (e.g., extreme confluence—the relentless lover whose boundaries are few), or when I am so blocked that I never want to experience "you" at all (extreme lack of contact—the narcissist who objectifies others). One of the main functions of the Gestalt therapist is to help the person understand how their blockages (unfinished business) prevent need satisfaction and result in an inability to meet another person fully.

Finally, Perls believed that one may be able to transcend ego functioning and have no sense of self. This Zen meditative state is considered a spiritual state by many who believe that ego functioning

binds us to a known reality that can be transcended. Some consider this to be the highest state of spiritual awakening.

Need Satisfaction Cycle

Perls identified several stages that illuminate the process of satisfying a need (Clarkson, 2013; Perls et al., 1951). This *need satisfaction cycle* starts at what Perls called the *zero point*, or *withdrawal stage*, in which a person is calm, and experiencing is minimal. At some point after this restful period, the individual experiences a new *sensation* as a "figure" arises out of the background (e.g., as I'm walking down the street, I smell a pie cooking; this becomes my foreground). Next, the individual gains an increasing *awareness* of a need that is closely related to the sensation (I realize I'm hungry). The individual then moves into the *mobilization* phase, wherein plans are tentatively made to address the emerging need (I look around, find the bakery where the smell is coming from and realize I can go buy a pie). *Action* is the next step, in which the individual takes steps to address the need (I walk over to the bakery). Then, through our sensory and motor functions (sensing, touching, moving, hearing, and feeling) we make *contact* with the object that will meet our need (I buy the pie, hold it, and ready myself to eat it). After contact is made, *satisfaction* is found in taking in the object (Yes, that does taste yummy!). Finally, we find ourselves back in withdrawal (the zero point), where the individual moves back into a state of calm (see Figure 6.3). The body is at rest, and we no longer need to strive to attain something, whether it is food, sexual excitement, an intellectual pursuit, or so forth. In fact, Perls suggested that this zero point was similar to certain meditative states, and we should try to extend this zero point to experience what he called the *void*. This tranquil and vacuous place is beyond need and gives the individual a sense of nothingness and, simultaneously, a sense of connection to the universe.

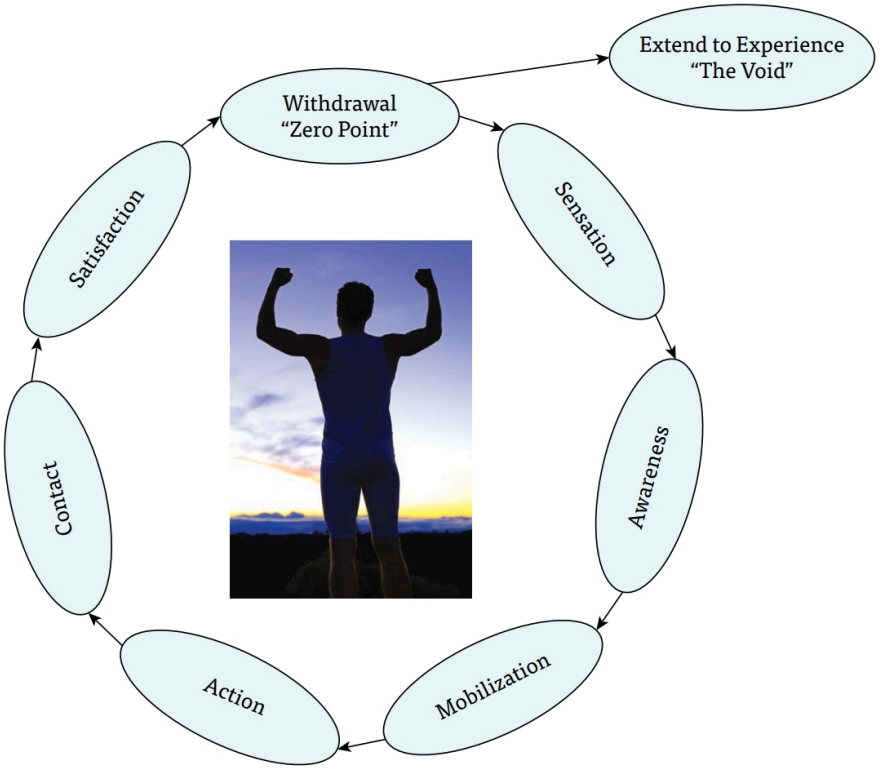

FIGURE 6.3 Need Satisfaction Cycle

Perls saw this cycle as being ongoing and seamless. For instance, consider the endless needs you have during the day, including such things as hunger, sexual feelings, the need to be close to a significant other, the need to accomplish a work task, and on and on. There is an ongoing ocean of needs to which we attend and try to meet in some fashion. Not meeting a need leads one to feel unfinished. Not having met a significant need from the past yields unfinished business, which we carry around with us in the background of our experiences, unaware that it is affecting many or all our relationships in some manner.

Unfinished Business

Unfinished business is when the incompletion of a need attainment leaves an individual feeling unresolved (i.e., the gestalt is not complete) and results in some type of neurotic or unhealthy behaviors (Mann, 2020; Wollants, 2012). Sometimes, the lack of completion is only temporary and can be resolved in a relatively short amount of time, such as when you might have a temporary conflict with a person. It sits with you for a while, but then, you decide to sit down with the person and talk it through—it becomes resolved and no longer lingers in the background.

Other times, the lack of completion of a need impinges on a person for long periods of time. In these cases, the individual uses one or more of several mechanisms to push the desire for need completion out of awareness. This is when the self develops *blockages* and *resistances* to one's experience. The resulting lack of awareness is equivalent to what others have called "the unconscious" (Yonteff, 1976). When this occurs, the individual's whole being spends energy on ensuring that the need is not met, which results in a neurotic lifestyle that is indicative of one's unfinished business. Such behavior is generally the result of parental shoulds or societal and cultural injunctions that are contrary to need fulfillment. As an example, if a client was taught by their parents "not to cry" at the loss of a loved one, then when a significant loss occurs, this child's whole being goes into a noncrying mode. Their thoughts say "do not cry," sadness is held back, their body tenses up to keep up the façade, and their tear ducts become blocked. Their whole being is affected, and they do not allow the experience of grief. And when faced with related situations in the future, they respond similarly. This becomes their unfinished business and can be held in their body for years. At some point in this person's life they may seek therapy, and as they peel away the layers of phoniness that are a product of their attempt to not experience grief-associated sadness, they will again be faced with the experience of the early loss and have a renewed opportunity to encounter it fully. This time, in the safety of the therapist's office, they can be real and work it through—complete the Gestalt and make themself whole again.

FIGURE 6.4 Gestalt Completion Test

Closure

As with the concept of figure/ground, Perls also borrowed the idea of *closure* from researchers in the field of Gestalt psychology, who were studying how the brain tends to want to complete (close) perceptions (Mann, 2020; Perls, 1969a). As an example, look at the drawings in Figure 6.4. The Gestalt psychologists used such figures to show how there was a natural tendency for us to complete the figures. Most people have little or no trouble recognizing the top-left and bottom-right figures (Street, 1931). The bottom-left and top-right figures are a bit more difficult to recognize—and, yet,

we struggle to complete the figures. Similarly, think about how many hours of fun children have completing connect the dot pictures—as if they inherently need to find out what the drawing is. Perls, however, extended the Gestalt psychology ideas by suggesting that the need for completion, or the desire to find wholeness, was inherent in other aspects of our being. Thus, whenever we have blockages that result in unfinished business and neurotic symptoms that prevent us from experiencing ourselves fully, the individual has an inherent need to once again become whole; that is, to take themselves back to a more normal state (see Box 6.2).

BOX 6.2 Closure and Resolving Unfinished Business

Consider, for instance, the individual who, at 10 years old, lost their father to heart disease. Following their father's death, significant others told them they'd better take care of themself; otherwise, they too might die an early death. Hearing these concerns, they introjected these values, or took them in whole, without processing them. As a result, throughout their life, they became obsessed with health to the point where they rarely experienced joy. They obsessively washed their hands. They did not enjoy eating, as they were always watching what they took into their body and ate only "healthy" foods. They worked out compulsively and became an ultra-marathoner. Then, they went into therapy. Their unfinished feelings about the loss of their father along with the introjected values from significant others had become directed toward a regimen of health, yet they were unaware of this. As they continued in therapy, they realized the sadness they still held about the loss of their father and also realized they often listened to the introjected voices that told them to be healthy. They slowly began to realize they did not listen to their own inner voice about how to address the needs of their body. Acknowledging this in therapy, their body responded by "letting go," and they slowly began to feel "free" again. Soon, they began to let go of their obsession to be healthy as they began to realize that being healthy is "good," but being obsessed about health is not.

Resistances or Blockages to Experience

> The introjector does as others would like him to do, the projector does unto others what he accuses others of doing to him, the man in pathological confluence doesn't know who is doing what to whom, and the retroflector does to himself what he would like to do to others. (Perls, 1973, pp. 40–41)

Although not stated explicitly, Perls would likely have agreed with Carl Rogers's notion of *conditions of worth*, which suggests that the expectations of significant others can result in individuals responding in ways that are not natural or true to self. Such conditions would result in unfinished business when dictates or injunctions from significant others are contrary to the way the body might naturally respond to a need. Perls and others (Mann, 2020; Perls, 1942/1947, 1973; Perls et al., 1951; Sills et al., 2012; Wollants, 2012) suggested that the individual might use several mechanisms (i.e., *resistances* or *blockages*) to prevent themself from experiencing a need, including *introjection*, *projection*, *retroflection*, *desensitization*, *deflection*, *egotism*, and *confluence*. Each of these mechanisms is a sign that there is unfinished business that needs to be addressed.

- **Introjection** involves the "swallowing whole" of the values of significant others without ever really examining whether one actually holds those values. This process results in one's responding in ways congruent to the values one is being asked to adhere to but incongruent to how one actually feels. Sometimes, the counselor can see the introjection of certain values

through the client's nonverbal behaviors. It's as if the client is saying one thing but really believes in something else. In this case, the whole body responds in a restrictive manner to prevent awareness of the fact that the individual really does not believe what they are saying. Ask the person if they believe in that value, and the answer would be "yes." However, look at the person, and their body says "no." Try acting "as if" you believe in something you don't for one day, and see how much energy that takes. Or as Perls (1973) stated: "[T]he man who introjects never gets a chance to develop his own personality, because he is so busy holding down the foreign bodies lodged in his system." (p. 34)

- **Projection** occurs when an individual sees attributes in others that are, in fact, their own. This "disowning" of a part of self allows the individual to delude themself into believing they do not have that quality. If one sees others as being "lustful" and criticizes them for it, they do not have to own up to their own sexual feelings. Such a process prevents them from owning a part of themself, and they end up living as a "phony," as Perls liked to say.
- **Retroflection**, which is like repression and *inhibition*, is the holding back of an impulse intended toward others and substituting it with another one toward self. On the one hand, the impulse is attempting to show itself; on the other hand, it is held back by the body. Thus, when I encounter a "friend" with whom I have ongoing anger issues, my body tenses up as I try not to show the person my anger. Instead, my friend might see a tense jaw, a clenched fist, or even a tic, as I attempt to withhold the impulse. Or as I listen to my sibling tell me the sad news about her chronic illness, my eyes start to moisten, but not wanting to show her my sadness, I hold back my tears, and my eyelids start to quiver, as I don't allow myself to cry.
- **Desensitization** is the dulling or numbing of one's senses in an effort not to experience and can be contrasted with the letting out and then holding back found in retroflection. It is the friend you have who never seems to show emotion, or the calm boss you have, who seems to be totally in control all the time.
- **Deflection** is finding ways of avoiding contact with another person by redirecting a potential encounter. For instance, one may look away, laugh a great deal, talk a great deal, use intellectual language, be overly polite or overly rude, change topics frequently, and so forth. A technique that we all have used at times, deflection allows us to avoid the reality of the moment. For instance, consider an individual who notices that they and their partner are not getting along. To resolve the conflict, they might say, "I'm sensing that there's something going on with us because I sense a lack of closeness." Rather than dealing directly with this statement, the partner might change the subject or state that things are really busy at work (when they're not—the partner is being a "phony") or state that "I'm tired and not getting enough sleep." All of these are ways of "deflecting" the accurate observation of this person's partner.
- **Egotism** is the overinvolvement with self that prevents real contact with others. With egotism, there is a meeting of two people; however, due to the self-absorbed attitude of one of the individuals, actual contact is never really achieved. You have certainly known people who talk so much that they have "tuned you out." Start talking to them about a serious matter, and they endlessly talk about themselves, or they tell you their opinion without listening to your responses. It's as if they live in a world of their own. It seems they do not have the ability to have a give and take with another person. For instance, a woman who was molested as a child could take on an egotistic attitude around men because of their fear of connecting with men. In this case, a horrible event earlier in their life has resulted in the creation of a resistance toward contact with men.
- **Confluence** is the blurring or dissolving of boundaries between people that results in a loss of identity and the inability to clearly define the self. Although we are all born into a state of *confluence* (i.e., our selves are indistinguishable from our parents' selves), as we grow, we increasingly develop a sense of "I" as separate from "you." With confluence, certain words

and phrases are used to suggest that others are included in one's experience or assumptions about the world. It is the boyfriend who states, "Come on, I know you'll love this movie"; the mother who refuses to see her teenage daughter's emerging sexuality and says, "I'm glad you're not like some of those kids at your school"; or the colleague who states at a meeting, "I know there are others here who feel the same way that I do." *Isadore From*, a colleague of Perls, stated that when individuals make assumptions about what others "know," they are often avoiding taking personal ownership for a belief and are trying to pull others into their belief system. Such statements prevent individuals from experiencing their differences—differences that are an important aspect of identity development.

Therapeutic Techniques

Gestalt therapy offers a flexible approach that helps clients move toward a place of openness with themselves and others. Although there are differing views of how techniques are used in Gestalt therapy, or whether to use them at all (see Box 6.3), this section will highlight commonly used and specialized techniques.

BOX 6.3 A Word of Warning About Techniques

When I (Neukrug) was editing an encyclopedia on counseling and psychotherapy theories, a well-known Gestalt therapist did not include any techniques in his write-up on Gestalt therapy. When asked about that, he said something like: "You know, the real Gestalt therapist does not use techniques because they are much more concerned about the real encounter between the client and the therapist, not the use of some type of artificial techniques." He had a good point! So when you read these "techniques," take into account that their purpose is to increase contact with the self and others, and when they become too "technique like," they're probably not serving their client well.

Commonly Used Techniques

Depending on the therapist's personality style, there are several commonly used techniques that most Gestalt therapists employ. These include *empathy*, *being directive*, *being confrontational*, *avoiding intellectualizations*, *focusing on nonverbal behaviors*, and *being willing to experiment*.

Empathy

Because Gestalt therapy is based on existentialism and phenomenology, *empathy* is an important tool to use to build the therapeutic alliance and a mechanism to understand the client's perspective of the world. However, most Gestalt therapists believe that in the long run, the sole use of empathy, as proposed by person-centered therapists, tends to slow the therapeutic process down, and they will, therefore, employ more active and directive approaches as sessions continue.

Being Directive

As Gestalt therapists feel increasingly comfortable with the client and as the relationship builds, they will embrace a more directive style. *Being directive* generally occurs when a counselor picks a specialized technique and asks the client to participate in the proposed activity.

Being Confrontational

Whereas being directive has to do with asking a client to participate in a specialized technique, *being confrontational* occurs when the therapist tells the client they are preventing themselves from experiencing, are being manipulative, or are acting like a phony in some way. Perls was particularly adept at confronting clients, although some also saw this as his fatal flaw, as he would often tenaciously challenge clients by telling them they were hiding, acting like babies, being a phony, and not being real (see Box 6.4). Therapists, today, are less likely to be this confrontational, although challenging a client is still an important tool for some therapists.

BOX 6.4 Gestalt Therapy Today

When watching Perls's work, there was little doubt that, much of the time, he was a masterful therapist. On the other hand, he could often be seen using heavy-handed confrontation, as noted in his biography. Unfortunately, students sometimes assume that Gestalt therapy is *the way* that Perls practiced the approach. This is not the case, and an effective Gestalt therapist today is able to balance direction and confrontation in ways that gently push the client to greater awareness.

Avoiding Intellectualizations

Clients have an enormous capacity to intellectualize their lives away, and many Gestalt techniques are geared toward *avoiding intellectualizations*. Perls even warned against the use of "why questions" or other techniques that "produce only pat answers, defensiveness, rationalizations, excuses, and the delusion that an event can be explained by a single cause" (Perls, 1973, p. 76). Instead, Perls encouraged counselors to use "how" and "what" questions, as they actively push clients toward experiencing themselves (e.g., "How does that feel?" or "What are you experiencing now?"). Counselors are also encouraged to direct clients to "show the therapist" how an experience might look by acting it out in the office or by demonstrating a conversation or interaction in the office. For instance, rather than a client telling the therapist how sad it would be if they broke up with their lover, the therapist might say, "Okay, have a conversation with your lover, right here, right now."

Focusing on Nonverbal Behaviors

Influenced by the work of Reich, Perls believed that our unfinished business is housed in our bodies. Thus, he suggested that *focusing on nonverbal behaviors* holds the key to understanding issues that remain unresolved. By focusing on and having clients exaggerate nonverbal behaviors, he believed, the Gestalt therapist can bring out these unresolved conflicts. Thus, a person who is constantly smiling is asked to smile more; as they do, they realize they are smiling to always show the world a "happy face." They quickly realize that they were taught by their parents to always show the good side of life and not express sadness. Thus, the smile helped to hide their deep sadness concerning failed relationships with the significant others in their life. Also, individuals are sometimes asked to "be" the nonverbal behavior. For instance, a person who is tapping their foot is asked to "be the foot" and to talk as if they are the foot. As they talk, they begin to say, "I'm trying to crush my father for the way he treated me."

Experimenting

Although most, if not all, of the specialized techniques you are about to read are experiments in experiencing at greater depths, Gestalt therapists generally feel free *experimenting* by spontaneously creating new techniques if they will assist clients in deepening their understanding of self and widening their awareness. In fact, for many Gestalt therapists, this is viewed as the creative aspect of Gestalt therapy, as they spontaneously develop new ways to confront the client's particular resistances.

Specialized Techniques

Gestalt therapy also uses a wide range of specialized techniques to increase client awareness of unfinished business that has prevented authentic contact with others. Some of the many specialized techniques identified over the years include *using now language*, *I–Thou communication*, *I–It language*, *experiencing the present*, *not gossiping*, *making statements out of questions*, *the dialogue game and empty chair technique*, *"I take responsibility for that," playing the projection*, *the exaggeration technique*, *feeding the client a sentence*, *"I have a secret," making the rounds*, and *dream work*.

Using "Now" Language

Clients can easily move away from their experience by using *there and then language*; that is, talking "about" something that occurred, as opposed to being in the here and now. Thus, one job of the therapist is to redirect the client's focus to the present—what some call *here and now language*. In fact, when clients would use there and then language, Perls would sometimes accuse them of relaying "elephant shit," implying that what they were saying was a bunch of crap and encouraged them to "get to work" and be in the "now." To get clients to experience the present, counselors will ask such questions as, "What are you experiencing or feeling now?" And when clients begin to talk about the past, they are generally redirected to talk about the present or to talk about the past as if it was the present. So if I were to begin to talk about the death of my mother and how I wish I had been there when she had died, my Gestalt therapist might say something like, "Why don't you have a conversation with your mother, now, and tell her how you feel about not being with her when she died?"

I–Thou Communication

People become very adept at not encountering one another and avoiding the *I–Thou relationship*, and the language they use reflects this. For instance, a client comes in and says, "I'm so pissed off at the world." In this case, the Gestalt therapist might try to have the client focus upon exactly who their angry at by asking, "So who are you angry at?" Then, the counselor might encourage the client to have a discussion with that person, either in the office as a role-play or with the person directly. Another example is when a client comes in and says, "I wish I had a more loving relationship." In this case, the counselor might say, "Can you tell your wife, lover, friend, etc. that you want more love in your relationship?" In both these cases, the therapist is pushing the client toward *I-Thou communication* where they are having a real relationship with the person with whom they have unresolved feelings.

I–It Language

One mechanism that clients use to avoid experiencing fully is the use of the word "it" as opposed to "I" (i.e., *I-It language*). For most clients, saying, "It just doesn't feel right" is not as powerful as

saying, "I just don't feel right." Or a client saying, "The world sucks" is not nearly as powerful as saying, "I suck" or "My life sucks." Here you can see how the simple change of the externalized "it" language to carefully choosing language that encourages ownership of feelings can move clients toward taking responsibility for their thoughts, feelings, and actions.

Experiencing the Present

Helping clients get in touch with their moment-to-moment experience and bodily sensations is critical to helping them gain *awareness* of their *impasses* and unfinished business. Counselors can help clients with *experiencing the present* in many ways, such as simply saying to them, "Listen to your body" or "Experience whatever's there." When I (Neukrug) underwent my own Gestalt therapy, my therapist had a very simple and effective technique of helping me experience the moment. Right after I would sit in my chair, he would ask me to close my eyes, take a few deep breaths, and tell him whatever I was feeling, sensing, or hearing. I was amazed at the blocks to my experience I could uncover within a short amount of time.

Not Gossiping

A particularly good technique for couples, family, or group work involves talking directly to an individual who is in the session, as opposed to talking about that person (i.e., *not gossiping*). For instance, a husband in couples counseling might complain to the therapist that his wife sleeps too much and does not take good care of her health. In this case, the therapist might simply state, "Why don't you tell them that directly? Your wife is right here."

Making Statements out of Questions

> The majority of questions the patient asks are seductions of the intellect. (Perls, 1973, p. 77)

While I (Neukrug) was in Gestalt therapy, I had the opportunity to hear Albert Ellis, the originator of rational emotive behavior therapy, talk. He was going on and on about how people should be allowed to do "whatever they want to" in life. I raised my hand and asked a question that went something like, "Well, you can't let anyone do whatever they want; for instance, what about when a person wants to rape someone?" Being a little phobic of public speaking and having asked my question in front of hundreds of people, I was quite proud of myself. A couple days later, I went to see my Gestalt therapist for our scheduled session. I relayed my story. He looked at me and said, "Who do you want to rape?" Now, to this day, I don't believe I wanted to rape anyone, but my therapist's question did evoke some interesting responses. Gestalt therapists believe that all questions are actually statements about self—that we are *making statements out of questions*. Next time you ask a question, think about what statement about yourself you might be making.

The Dialogue Game and Empty Chair Technique

If you remember from earlier in the chapter, Gestalt therapists believe that our personality possesses a wide variety of polarities, and sometimes one is dominant over the other. Called a split in one's personality, such a dichotomy is generally the result of unfinished business that prevents the individual from being whole. Gestalt therapists believe it is important to acknowledge the nondominant part and integrate it back into the individual's personality. This can sometimes be accomplished through the dialogue game. For instance, if there is a struggle between a part of me that wants to be "nice" to my friend and a part that is pissed off at my friend, I can

play out the two parts. Or if there is a part of me that is a showoff, likely, there is also a shy part within. To emphasize such splits, a client can dialogue with an empty chair and have a conversation with the two parts of self. Often, the individual takes turns being each part and actually switches chairs as they speak to the other part of self in the opposing empty chair. Of course, it is important to pay particular attention to the nondominant side of self, as this side is often in hiding and has difficulty expressing itself. This *dialogue game* is often employed when exploring topdog–underdog splits.

The *empty chair technique* is also used when there are unresolved issues with a person whom the client cannot contact directly (e.g., an estranged spouse or a deceased person). In this case, the client can imagine the person sitting in the empty chair and can be prompted by counselor statements like, "Tell _____ what you're feeling," "What is it like to talk with _____?" and "What do you need to say to _____?" More specific material can be added based on the situation.

I Take Responsibility for That

Because clients are particularly adept at not taking responsibility for their actions, Gestalt therapists often ask clients to add a simple statement like "and *I take responsibility for that*." So "My marriage is a shambles" becomes, "My marriage is a shambles, and I take responsibility for that"; "This job sucks" becomes "My job sucks, and I'm responsible for that" (notice how "this job" became "my job"); or "I'm horribly depressed" becomes "I have created my horrible depression; I'm responsible for it." This technique pushes the client to take ownership of their feelings.

Playing the Projection

Because Gestalt therapists view all questions and statements about the world as statements about self, clients are often asked to take ownership of phrases they use that may have far-reaching implications—implications that the client is not aware of. So a client who constantly states, "This world is a scary place," is asked to role-play that projection. For instance, a therapist might suggest to the client, "Be scared and tell me what it's like to be scared." Or the client who states, "You can't trust anyone," might be asked to state, "I can't trust myself" or "No one should trust me; I'm untrustworthy." From these statements, which are projections of the inner world of the client, clients can work on deep-seated unresolved issues lingering within and affecting their everyday behavior. *Playing the projection* is particularly useful in family and group settings where the client can look at each person and make a statement about self to each member. For instance, a client might say to each person in the room, "I'm not trustworthy." This can often evoke deep emotions and help the client get in touch with unresolved issues. Members may or may not be given the opportunity to respond.

Exaggeration Technique

One relatively easy method of helping clients get in touch with feelings is to ask them to emphasize or repeat a word, phrase, or sentence. Accenting in this manner, while asking them to be particularly tuned into their inner experience, can help them release the feeling they're protecting themselves from. For instance, imagine a client who feels ashamed of their body and softly says, "I hate my body." That client would be asked to say the statement more loudly and then even more loudly. Soon, they are yelling it, and they realize how they have disconnected or split off themselves from their body. Saying the statement loudly by using the *exaggeration technique* makes them own their hated feelings toward their body and is the first step toward the polarity that they also feel—loving their body.

Feeding the Client a Sentence

As clients work on core issues, their unfinished business is sometimes obvious to the therapist but not to the client. Based on the therapist's educated "hunch," they will create a sentence that seems to highlight a core issue and ask the client to repeat it. So a client who is working on issues of closeness to women might be fed a statement like, "I am so scared that if I get close to a woman I will lose my sense of self." Accurately *feeding the client a sentence* can hasten the progress of completing unfinished business.

"I Have a Secret"

Most people have a part of themselves they feel guilty about or ashamed of. To take ownership of these feelings, a counselor will ask a client to make a statement about how the client thinks the therapist might respond if the secret was revealed. Or in a group setting, the client might go to each group member and reveal how they imagine each member would feel if the secret was revealed. If trust has been built, clients might be asked to reveal the secret and then ask each member how they feel about the client. This *I have a secret* technique allows the client to experience a disowned part of self and integrate it into their personality.

Making the Rounds

This technique of *making the rounds*, generally used in group counseling, is when a client is asked to make a statement to every group member, based on a theme on which they have been working. So a client dealing with issues of trust might go to each person and say, "Joe, I am scared of trusting you," "Georgette, I am scared of trusting you," "Jamison, I'm scared of trusting you," and so forth. The leader may or may not have each member reply. Or sometimes, the leader will have the member go around twice; the first time, each member does not reply, but on the second round, they do. Groups are notoriously good at assisting clients who are dealing with these core issues, and it is not unusual to have a group member reply with something like, "I care about you so much, and I hope you can come to trust me."

Dream Work

Gestalt therapists view dreams as representing projections of different aspects of the self. Therefore, they often ask clients to role-play a part of a dream that might stand out for the client. For instance, Perls would often direct clients to have conversations with different parts of their bodies that stood out in a dream or tell clients to have dialogues with different people that popped up in a dream. Such *dream work* helps to bring out hidden aspects of the person that are reflective of unfinished business, with the goal being to integrate split-off aspects of the person. Similarly, Perls believed we should embrace our nightmares, as they often include unacknowledged parts of ourselves (e.g., the boogeyman!), which must be embraced and integrated if we are to be whole. Dreams are also existential messages about our lives. If I have a dream about the world disintegrating, might that not mean that my life has no meaning and no direction? Finally, Perls felt strongly that therapists should not interpret dreams for clients, as that might lead to client intellectualization, which is the last thing you want clients to do in Gestalt therapy.

The Counseling Process

As you might expect from reading this chapter, the therapeutic journey of the Gestalt therapy client is like no other. Although each Gestalt therapist applies skills in different ways, the underlying

assumption is that whatever skills they use, the client will experience movement toward greater acceptance of feelings, increased openness toward experience, greater honesty and realness, an increased sense of self-support, and the ability to engage with another person in open dialogue and mutual discussion without holding back, called, by Buber (1958), the "I–Thou" relationship. In helping clients move toward these goals, Gestalt therapists vary in how direct and confrontational they can be—those like Perls tend to challenge clients, be provocative, and direct clients toward change, while others gently push the client and subtly challenge them to examine their unfinished business.

Whether the counselor is very directive and confrontational or gently pushing the client toward greater experience, a general unraveling of the client's world occurs in a predictable fashion. In describing this process, Perls identified five layers of which the client increasingly becomes aware as the client continues in therapy. Called the structure of neurosis, the layers include (a) *the cliché layer*, (b) *the role-playing or phony layer*, (c) *the impasse layer*, (d) *the implosive layer*, and (e) *the explosive/authentic layer* (Clarkson, 2013; Perls, 1969a; 1970; see Figure 6.5).

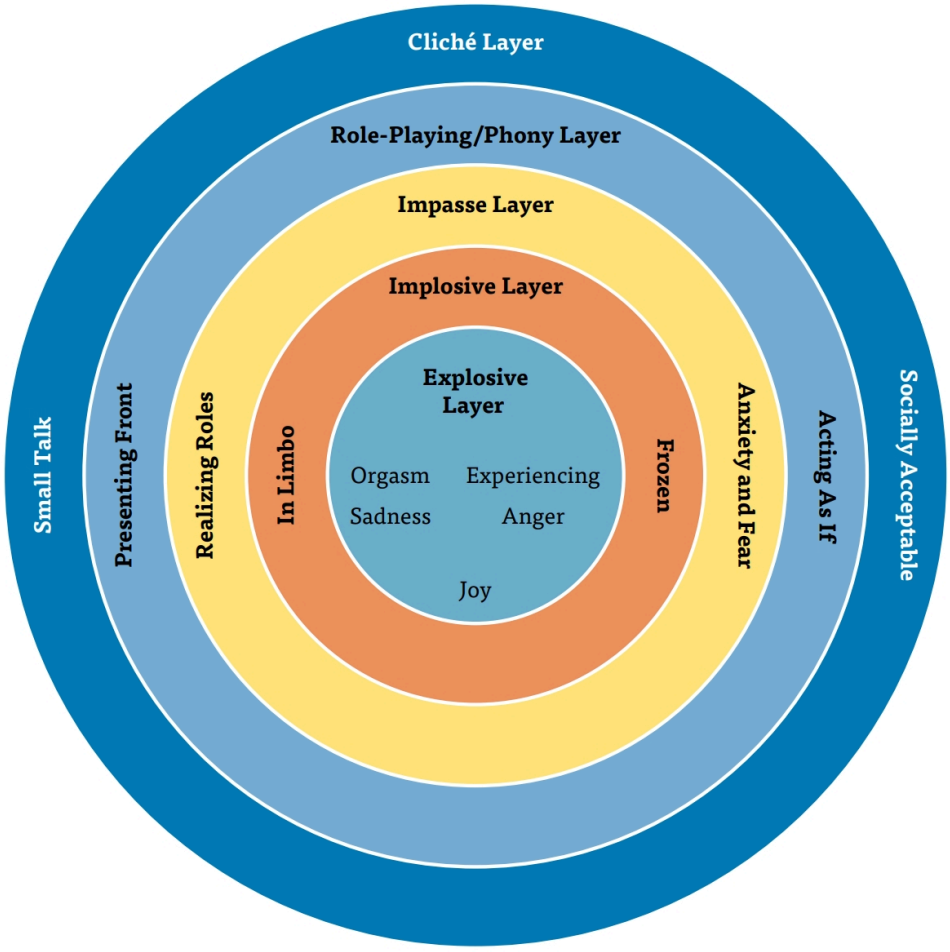

FIGURE 6.5 Structure of Neurosis

- **the cliché layer:** The *cliché layer* reflects typical ways that we act in our day-to-day existence when we're attempting to make small talk with others. It is the "socially acceptable" way we act with people as we pass them in the hallway at work, see them in the supermarket, or walk

by them on the sidewalk. It is the "you" who is depressed but responds with "Great!" when someone asks you, in passing, "How are you doing?"

- **the role-playing or phony layer:** One step below the cliché layer is the *role-playing or phony layer*, wherein we present a front to others to avoid actual contact. In this layer, we act "as if" we are a certain type of person as opposed to acting as we actually are. We might act superior, like a "big shot," coquettish, incessantly respectful, or a thousand other roles, but it's all a front to avoid contact. Perls suggested that this layer includes the "topdog" and the "underdog," or the part of ourselves that acts righteous and is demanding versus the part of us that is subservient and unsure of ourselves. Some examples of a phony might be the individual who acts like the "cool professor" in an effort not to show their real self to students, the business executive who is "in charge" all the time and uses their persona to seduce others to their point of view, or the psychologist who uses words in ways that suggest they are always analyzing others. All of these roles can seem real but, in the long run, prevent the person from having a genuine encounter with another person. Just below this layer is a part of us that tries to resist who we really are.
- **the impasse layer:** There is a Woody Allen movie called *Zelig* that depicts a man named Zelig who becomes whomever he is around. He is the ultimate "role-player." If he's around someone who is Chinese, he speaks fluent Chinese. If he's around someone who is obese, he become obese. If he's around a psychiatrist, he become a psychiatrist. During the movie, Zelig's psychiatrist comes up with a novel intervention when she tells him that she is not a psychiatrist. Zelig immediately freaks out because if she is not a psychiatrist, then he must not be one too. Suddenly, Zelig begins to have an anxiety attack, as he realizes that he doesn't know who he is. Zelig has come face to face with the *impasse layer*, or the point where he realizes that he has been playing a role his whole life. Realizing he has been living a false existence catapults Zelig into a state of anxiety as he contemplates, "If the psychiatrist is not the real me, who am I?" Coming face to face with the impasses also raises the question, "Dare I move beyond it?
- **the implosive layer:** As our fictitious Zelig hits the impasse, he must then decide who he really is. It is at this point that individuals often hit a wall and implode—or deaden themselves. They are fearful that if they were to really be themselves, they would not be loved. On the other hand, having knowledge that they have all along been playing a role, what should they do? It's hard to go back when one realizes that one has been fake. This *implosive layer* is a place of limbo—a place of waiting to decide what to do. It is a place in which one feels frozen in time. Frozen, that is, until one is willing to risk everything and be oneself.
- **the explosive/authentic layer:** Ultimately, one must decide—do I continue playing a role? Or do I risk being myself? When willing to risk, one experiences the ultimate layer, the *explosive/authentic layer of existence*. It is the layer in which the person again feels. It is a place of orgasm, aliveness, anger, and sadness, as the individual allows themself to be truly alive again. It is the place of experience.

Inevitably, one who has a successful experience in Gestalt therapy feels whole and renewed and has a much stronger sense of self. This person is in touch with their moment-to-moment experience and is increasingly self-supportive and self-reliant. This person is real and able to communicate directly and honestly with others.

Social, Cultural, and Spiritual Issues

Gestalt therapy is focused on the phenomenological or subjective experiences of clients. Thus, the counselor's approach is individualized to the client, as the therapists focuses on the client's journey through their unique environments.

> Now in any biological, psychological, or sociological investigation whatever, we must start from the interacting of the organism and its environment. ... Experience is ultimately contact, the functioning of the boundary of the organism and its environment, and that every human function is an interacting in an organism/environment field, socio-cultural, animal, and physical. (Perls et al., 1951, pp. 228–229)

But Gestalt therapists also need to be aware of their own experiences if they are to be culturally responsive:

> This is our work: to be fully present in our own fullness of person and culture, and to selectively and sensitively share our awareness with our environmental other, respectful both of our own cultural context and that of the other, and the interactional dynamics at the contact boundary between us. (Gaffney, 2006, p. 218)

The literature on cross-cultural counseling relative to Gestalt therapy is sparse, and that which does exist seems to extol its virtues. Gestalt therapy is adaptable to a cross-cultural perspective with its focus on phenomenological inquiry of the client's experience; the importance of understanding the contextual field of the client, including historical, cultural, and political influences; the encouragement for clients to become aware of their own experiences, including experiencing the "void," or the Zen notion of nonbeing; and the significance of contact, as the self constantly changes and transforms through interactions with others (Crocker & Philippson, 2005; Fernbacher & Plummer, 2005; Frew, 2016; Gaffney, 2006; Kirchner, 2000).

Despite these virtues of Gestalt therapy, clients, particularly those of marginalized and from non-Western backgrounds, may be uncomfortable with a number of aspects of the approach. Gestalt therapy challenges our very existence—our ways of understanding the world—and pushes us to experience memories, feelings, and thoughts we have long forgotten. Most individuals are simply not comfortable with that, especially marginalized clients who come from cultures in which the expression of feeling is not a priority. Gestalt therapy also challenges our ability to make contact with others and how we interact with others. It values the I–Thou relationship and suggests the I–It relationship is less important. So those that come from a collectivist culture that stresses deference to others and minimizes the Gestalt authentic give and take in relationships may feel put off by this approach. To them, "authenticity" is highly overrated. If one were to work with clients who have difficulties with some of the basics tenets of Gestalt therapy, it is critical to talk about the approach with the client, consider whether the client is amenable to such an approach, adapt one's way of working so that the client feels more comfortable, and sensitively move along, while constantly checking in with the client to ensure that one has not overstepped one's boundaries.

Some have also critiqued Gestalt therapy as having an overemphasis on individual responsibility, the importance of emotional expression, and the "here and now" of experience to reach optimal mental health. With the increased diversification of the United States and, thus, attention to multicultural and social justice counseling competency (Ratts et al., 2015), there has been greater focus on ensuring that Gestalt techniques and processes shift to meet the needs of the diverse client. For example, Frew (2016) notes that concepts derived from *intercultural communication* (ICC) theory may be applied to Gestalt therapy for more culturally responsive practice. *Edward Hall* (1914–2009) developed ICC based on his interest in the role of the unconscious in communication. Hall (1959, 1976) was particularly interested in nonverbal communication and the way proxemics (i.e., space) and chronemics (i.e., time) influence it.

Intercultural communication is interpersonal communication between members of different groups, which differ from each other in respect to the knowledge shared by their members and in respect of their linguistic forms of symbolic behavior (Bakic-Miric, 2008; Frew, 2016). The following

interdependent ICC concepts should be considered when practicing Gestalt therapy for culturally responsive practice:

- **curiosity:** *Curiosity* includes keeping an open mind in the moment to observe, describe, and wonder about the lived experience of a client. In this process, one is humble and uses phenomenological inquiry to understand the client's subjective experiences.
- **high context:** *High context* means there is a strong focus on how a person's meanings and intentions are expressed through their historical, cultural, situational, and relational contexts as well as nonverbally through symbols. Gestalt therapists should focus on including an understanding of the client's contextual world that is embedded in their individual and collective contexts.
- **indirect communication:** Within many societies and cultures *indirect communication,* such as nonverbal communication, takes precedence over spoken and direct message exchange. Since Gestalt therapists believe that our nonverbal cues are important messages about how we hold in our unfinished business, if used appropriately, this can be a mechanism to understand and connect with clients and discuss underlying issues.
- **collectivism:** *Collectivism* values collaboration, the extended family, and indirect, contextual communication. Since Gestalt therapy was developed with cultures that were primarily individualistic, and because increasingly large numbers of individuals in the United States have a collectivistic focus, the Gestalt therapist must have skills to adapt to individuals who come from a culture that values collectivism.
- **small power distance:** *Small power distance* refers to a set of values held in cultures in which the members of groups and organizations aspire to democratic and equal relationships. Since Gestalt practitioners value real and equal relationships, this can fit nicely with a Gestalt approach if the therapist doesn't push the client too much to be authentic in the relationship.

For individuals who identify as spiritual or religious, Gestalt therapy has its challenges (Carpenter, 2015). For instance, the approach suggests that cultural and societal injunctions and "shoulds," which are often based on writings from the major religions of the world, are one prime source of unfinished business, and their usefulness should be questioned. Yet it is these very injunctions and shoulds, found in religious doctrine, that are critical to living the moral and even spiritual life for religious people. Thus, on the one hand, the phenomenological stance of Gestalt therapy calls all therapists to hear the world of the client. On the other hand, knowing that "shoulds" derived from religious doctrine can lead to unfinished business may result in therapist bias toward religious clients. Therefore, careful consideration of whether any particular Gestalt therapist can work with a religious client must be carefully reflected upon by each therapist.

Relative to spirituality, if we mean Zen meditation and Buddhism, Gestalt therapy seems to hit the mark with its focus on holism, the "void," here-and-now awareness, and getting in touch with deeper aspects of ourselves (Crocker, 2015; Ingersoll & O'Neill, 2005; Wolfert, 2015). However, for most people, at least in the United States, spiritualism is not Zen meditation and Buddhism, and one has to wonder if Gestalt therapy has a place for a more traditional view of spiritualism. For instance, many mainstream religious people who identify themselves as spiritual may not easily relate to many of the previously discussed concepts. For them, spiritualism may be defined quite differently.

In the long run, Gestalt therapy seems to be a mixed bag cross-culturally. On the one hand, those who embrace Gestalt theory argue that the Gestalt approach is unique in its ability to see the client contextually and to understand the client within their unique understanding of the world. At the same time, the Gestalt approach has a firm footing in a view of human nature that stresses some values not embraced by all cultures (e.g., a focus on self ["I"] to the exclusion of the broader

community). In the end, when practicing Gestalt therapy, one must be tuned into the unique needs of the client and determine if the approach being used is appropriate to the client's cultural embeddedness (Frew, 2016; Sue & Zane, 2009).

Efficacy of Gestalt Therapy

As a therapeutic approach that examines the whole person, Gestalt therapy is one of the most difficult approaches to research, particularly because it is easier to look at specific aspects of behavior rather than examining some indeterminate concept called "the whole person." And even if we were to try and measure some "aspects of the whole," like the ability to "experience the now" or skills at "making contact with the environment," we run into some major methodological problems in deciding how we might measure such elusive concepts.

Despite these challenges, Gestalt therapy has been shown to be effective in individual and group settings with children, adolescents, and adults—particularly regarding improving clinical and social outcomes (Raffagnino, 2019; Stripling, 2021). For example, Gestalt therapy with individuals has been demonstrated to be beneficial in reducing substance abuse and bipolar disorder symptoms among adults (Dominitz, 2017) and decreasing psychological distress for individuals with childhood sexual abuse histories (Grande et al., 2017).

In group settings, Gestalt therapy has shown to be effective in reducing depression, anxiety, sexual trauma responses, and low self-esteem among girls who have survived child sexual abuse (Pretorius & Pfeifer, 2010), increasing body satisfaction for trauma survivors (Zielona-Jenek et al., 2019), increasing self-esteem for pregnant women who experienced intimate partner violence (Noormohamadi et al., 2021), decreasing depression among bereaved women (Hagl et al., 2015), increasing self-efficacy for divorced women (Saadati & Lashani, 2013), and promoting positive emotional self-expression and decreasing depression, anxiety, and trauma experiences among children and adolescents (Stripling, 2021). Group Gestalt interventions have also been demonstrated to be effective at addressing academic difficulties, such as academic procrastination behavior of high school students (Gading, 2020) and awareness and support for university students' personal development (Öztürk, 2019).

Additional research, including meta-analyses, has been conducted and found the following (Cooper, 2008; Hender, 2001; Johnson & Smith, 1997; Kirchner, 2000; Paivio & Greenberg, 1995; Schoenberg, 2000; Wampold, 2001; Winter, 2007):

1. Gestalt therapy is an effective treatment overall and is certainly better than no treatment.
2. When measuring overall satisfaction, Gestalt therapy is as good as behavioral therapy or cognitive therapy.
3. Gestalt group therapy is somewhat effective at reducing depression and anxiety.
4. The empty chair or two-chair technique seems to be effective at reducing anger, reducing unfinished business, improving decision-making, and the treatment of simple phobias.
5. The empty chair technique may be more effective than empathic reflections when measuring depth of experiencing, shifts in awareness, and conflict resolution.
6. There is some preliminary evidence that Gestalt group therapy might be helpful when working with individuals with borderline personality disorder (BPD).

The research above is limited, and more studies that examine the effectiveness of this approach with varying populations need to be undertaken. One hopeful sign is that since 2013 there has been a series of Gestalt research conferences that foster new research on Gestalt therapy (International

Conference on Research in Gestalt Therapy, n.d.). These conferences challenge those involved in Gestalt therapy to focus on its efficacy, and from the conferences, new research is developing.

The Millers

The following shows Angela going through Gestalt therapy. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Angela's Experience in Gestalt Therapy

Driving down the long country lane, Angela heard the gravel popping beneath her tires as she took one curve and then another. She realized that she hadn't been alone with her thoughts in years. Normally, her children would be in the backseat of the car creating a steady din, requiring her frequent intervention. On any other day Jake would be sitting behind the wheel, confessing to her one fear after another and pontificating about how to avoid disaster. But today, Angela was in the driver's seat. She felt a growing exhilaration as her foot pressed gently on the gas, and the car pulled forward with growing speed. By the time she reached Dr. Davis's office, her heart was pounding.

Dr. Davis was a rosy-cheeked woman of about 50; her eyes danced as she invited Angela to sit in one of the overstuffed chairs in the middle of the room. "You seem flushed," Dr. Davis noted, handing Angela a glass and motioning to the pitcher of water sitting on the coffee table next to her. Angela sat, looking into her lap, and began, "I had such a strange experience driving here today. It was as if there was a part of me aching to be free; I felt myself pushing the car forward faster and faster, pulling around those tight corners. I don't think I've ever done anything so reckless. I don't know what got into me." After drinking deeply from her glass, Angela began to explain why she had come. She described Jake's anxiety and the pressure and tensions that had resulted between them and with their children. Angela also described her experiences in childhood of caring for her sister on long, hot afternoons in Nigeria, wishing she could go outside and play with the other children.

Dr. Davis, a Gestalt therapist, believes that each of us strives to fulfill our most basic needs but that our needs can be thwarted by familial and social expectations. She believes that, based on these expectations, our identities are formed and are comprised of polarities of contrasting traits, some of which we find acceptable and work to express and others we suppress or deny. As Dr. Davis listened to Angela, she noted the ways in which Angela seemed to have closed off parts of herself that she had found unacceptable—for example, the parts of her that would have liked to acknowledge her own needs and the part of her that felt angry.

"You seem far away right now. What are you feeling now?" Dr. Davis prompted.

"I feel guilty—ashamed, too, I guess," Angela admitted.

"Say more about that, Angela," Dr. Davis prompted.

"I don't feel comfortable with this feeling. The feeling of wanting a little freedom or the thrill that I feel at the thought of it. After all, I should be a good support for my family—that's my job," she said, turning her wedding ring nervously.

"You are doing something with your fingers there," Dr. Davis commented, noticing Angela twisting her wedding ring in circles up toward her knuckle and back down again. "Do that more," she instructed. Angela blinked curiously at Dr. Davis and began twisting the ring faster and more dramatically. Dr. Davis leaned forward. "Now, Angela, with more gusto!" Angela focused on her ring, twisting it more quickly and with more energy; tears gathered in her eyes. "What are your fingers telling you, Angela? Have them talk to you. What are they saying?"

Angela looked at Dr. Davis puzzled, thought a moment and then responded, "Break free! They seem to say, 'Break free!'"

"Yes, Angela, allow that voice," Dr. Davis prompted.

"Break free. Break free. Break free," Angela continued. The words vibrated through the room. As she repeated herself a third and fourth time, Angela's tears began to stream down her cheeks.

"It seems you've liberated your tears," Dr. Davis noted. "Tell me, what do you want to be free of?"

"As long as I can remember I have been taking care of someone. Now, all the dreams I had in college have been subverted by my role taking care of my kids, my husband, and my sister. Part of me would like to be free of all these responsibilities," Angela confessed.

As Dr. Davis reflected on her first session with Angela and began to consider her treatment plan, she noted that she would like to help Angela more fully experience her life and the full richness of her emotional self in the here and now, including her repressed need for autonomy. As a Gestalt therapist, Dr. Davis views Angela's difficulties as unfinished business. She believes that because Angela's early needs for freedom and fun were thwarted by cultural and parental expectations, Angela's unmet needs were blocked from her awareness and became unfinished business. She believes that Angela's inability to acknowledge and experience these needs led her to live a phony and inauthentic life as she played the role of the perfect wife, mother, daughter, and granddaughter. For Angela to become more authentic, she would have to be able to work on the unfinished business that maintained her inauthentic way of being, mask of niceness, and unflagging nurturance.

In the weeks that followed, Dr. Davis worked to help Angela see that she had introjected her parents' expectations, swallowing whole their demand that she always be ready to care for others. She worked with Angela to acknowledge her needs by making use of specialized techniques and experiments, like the exaggeration technique described earlier. Dr. Davis encouraged Angela to remain in the here and now as she expressed her feelings and experienced.

One afternoon, Angela came to the session trembling. She seemed to be having difficulty looking at Dr. Davis as she sat in her usual spot on the couch, gazing at her hands resting in her lap.

"Angela, help me understand what is happening to you right now," Dr. Davis asked softly.

"I feel like I am back at square one. I've been wasting my time here!" Dr. Davis waited as Angela sat crying into a tissue, unable to continue. "Yesterday, my grandmother called. She told me that Lillian, my younger sister, needs help. She just had hip surgery, and I went to Philadelphia for the entire summer to help her out with her kids. Now, my grandmother is telling me to go back there and help her out some more; she just isn't doing well enough on her own. This is really bad timing. I don't know if it is a good idea to leave Jake and the kids to fend for themselves, just when Jake is starting to get help for his anxiety. I feel like there are two parts of me—the independent me and the connected and sometimes dependent mother and wife. And I guess if I were to be honest, I feel a little resentful because of your need to have me be independent. I don't think you really understand that my obligations to Jake and the kids and to Lillian and my extended family are more than just obligations. They are my connections to them, and it is the way that I am bound to my family and them to me. It is a part of my culture, and I don't think that I can just reject that part of me and still be real. My obligations to Jake and the kids are a part of me, too."

Dr. Davis paused a moment, considering, and then replied, "You've felt that to be real with me you had to be independent Angela—the Angela who ignores her family obligations and ignores her culture? Angela, can you say more about the anger you feel at me for pushing you to be independent?"

"It makes me furious! I come here, so you can help me, and you haven't really tried to understand at all!" Angela responded.

"Help me understand more fully what the real Angela looks like," Dr. Davis said, nodding her encouragement.

"Well, the real Angela can decide how I am going to take care of my kids, Lillian, and myself all at the same time." Angela paused, then said, "I think what I really want is that I wouldn't have to trade in the part of me that cares for others and supports my family for the part that needed attention and needed to be heard. No, I want to let both parts of myself have a voice."

"Say that again, Angela," Dr. Davis prompts. "Say it loudly. 'I want both parts of me to have a voice.'" Dr. Davis's work with Angela had been focused on supporting Angela in discovering how to integrate polarities into a cohesive whole and cultivate a genuineness that would allow Angela full contact with the world and with her own experiencing. Angela's cultural frame was and will continue to be a big part of who she is. Giving this aspect of herself adequate attention in therapy was vital to Angela in being able to understand how her polarities of self- and other-care can be integrated, so she can make decisions about her life that are consistent with her needs—those she has been aware of as well as those she had once submerged.

"I've made my decision," Angela began in her last session with Dr. Davis. "The school year will end in six weeks. I will go to Philadelphia and help Lillian on the weekends. I'll take care of the big chores, and she can rest. And then, if she still needs help when school lets out, I will take the kids up there for another couple of weeks."

Dr. Davis smiled. "But this time, you are making your decision aware of all parts of yourself—the strong, autonomous part and the strong, committed-to-family part."

For You to Consider

1. When Angela came in to see Dr. Davis, she said she wanted to "break free." What do you believe Angela needed to be free of?
2. Angela's need for freedom and autonomy was not fully experienced due to one or more of the following resistances or blockages to her own experience: introjection, projection, retroflection, desensitization, deflection, egotism, and confluence. Explain which of these mechanisms Angela likely used to prevent herself from experiencing this need fully.
3. What special attention did Dr. Davis need to give to Angela's cultural frame to help her fully integrate all parts of herself? If you were working with Angela, how do you think you would help Angela make sense of her American and Nigerian identities?
4. Do you think that Dr. Davis wanted Angela only to be independent, as Angela asserted?
5. How comfortable would you feel asking a client to "talk to their fingers" or another body part?
6. What other techniques do you think would be effective for Angela's work in dealing with her unfinished business and integrating repressed parts of herself?
7. Using Perls's notion of the structure of neuroses, explain the therapeutic process as Angela experienced it.
8. When you consider Jake's personality, what parts of himself does Jake seem to reject? Which parts does he embrace?
9. Do you think that Jake and Angela's expectations of Luke may lead Luke to begin to cut off parts of himself? How might rejecting parts of himself look for Luke as he grows to adulthood? How about Celia?
10. Do you think this approach would be effective with the whole family present at the same time? Why, or why not?
11. What polarities do you experience in your own personality? What parts of you do you think of as bad? What would integrating or embracing those parts look like in your life right now?
12. Are there times when you feel you are wearing a mask or being phony? What makes it difficult to let go of these masks and be real in your relationships with others?

13. Using Perls's notion of the structure of neuroses, explain where on the circle you see yourself most of the time.
14. Being a Gestalt therapist requires a bit of the theatrical and some risk-taking. Do you think this is something you could do? If not, is it because you have cut off a part of yourself?

Summary

Gestalt therapy was developed by Fritz Perls during the 20th century. Growing up in Germany, Perls eventually obtained his medical degree and subsequently fled Nazi Germany during the 1930s. Going to South Africa and later to the United States, Perls was influenced by many people and philosophies over the years, such as the anti-deterministic approach of the existentialists; the belief that each person's reality is unique and true for that person (phenomenology); the holistic notion that mind, body, and soul act in unison; and a number of ideas by the Gestalt psychologists, including the concept of figure/ground and closure. His theory would become a novel approach to therapy and one of the first theories developed in the humanistic tradition. In line with this tradition, Perls suggested that people are born neither good nor bad and with the capacity to embody many personality dimensions. Being holistic, he deplored the reductionistic approach of the Freudians and experimental psychologists and suggested that the whole being cannot be broken down into separate parts. Some of the key concepts we explored that are basic to the Gestalt therapy approach include holism, figure/ground, polarities, contact, the need satisfaction cycle, unfinished business, closure, and resistances or blockages to experience.

Key to Perls's theory are the ways in which people have their needs met and make contact with their environment. Indicative of this process is a cycle that includes withdrawal (or rest—"zero point"), sensation, awareness, mobilization, action, contact, and satisfaction. For the Gestalt therapist, how the individual makes contact with their environment in an attempt to satisfy needs is reflective of the individual's way of being in the world and determines the self. Parental injunctions, as well as cultural and societal pressures, could prevent the normal attainment of needs and be the impetus for the development of blockages and impasses in a person's life that create unfinished business. Perls and others have identified a number of resistances, or ways that individuals block themselves from experiencing, which ultimately create unfinished business, including introjection, projection, retroflection, desensitization, deflection, egotism, and confluence.

Gestalt therapists believe that the ultimate way of living is allowing oneself to access all of what is available to one's experience. Since unfinished business prevents fully experiencing, one goal of Gestalt therapy is to help the client once again experience the "now" that is the basis of the client's reality. In Gestalt therapy experience = awareness = reality. To help clients experience the now and integrate lost parts of themselves, a number of techniques have been developed, including using now language, I–Thou communication, I–It language, experiencing the present, not gossiping, making statements out of questions, the dialogue game and empty chair technique, "I take responsibility for that," playing the projection, the exaggeration technique, feeding the client a sentence, "I have a secret," making the rounds, and dream work. In addition, Gestalt therapists use a mixture of empathy, being directive, being confrontational, avoiding intellectualization, focusing on nonverbal behaviors, and experimenting with the creation of new ways to help the client experience. These techniques are used to help clients traverse the structure of neurosis, which Perls suggested included five layers: (a) the cliché layer, (b) the role-playing or phony layer, (c) the impasse layer, (d) the implosive layer, and (e) the explosive/authentic layer.

Cross-culturally, Gestalt therapy appears to be a mixed bag. On the one hand, the Gestaltists highlight the fact that it is adaptable to many cultures, since it is based on phenomenology and is, thus, respectful of all viewpoints and because it stresses understanding the contextual field

of the client, including the client's historical, cultural, and political influences. However, from a much more basic stance, many diverse clients would have difficulty with the approach, especially those who come from cultures that are less expressive of feelings or do not value the importance of "authenticity"—perhaps deferring to the collectivist nature of their culture instead. Some suggest that concepts derived from intercultural communication can be useful in working with diverse clients. Some of these include curiosity, having a high context orientation, understanding indirect communication, knowing about a collectivist perspective, and understanding about small power distance (equality and democracy). Spiritually, those who adhere to Eastern philosophies may feel comfortable, as the Gestalt approach borrows much from them. However, traditionalists might see the Gestalt approach as somewhat odd and nonsupportive of many of the values of mainstream religions.

With its emphasis on holism and other somewhat elusive concepts, methodologically, Gestalt therapy has a number of challenges to efficacy research. For the relatively small number of research studies conducted on Gestalt therapy, it has been shown to be effective in improving clients with a wide variety of symptoms. Some research suggests that Gestalt therapy is better than no treatment and as good or better than behavioral or cognitive therapy. In addition, Gestalt therapy is effective in reducing anxiety and depression, the empty chair technique works particularly well with some symptoms, and Gestalt therapy might be effective for patients with borderline personality disorders. The recent International Conference on Research in Gestalt Therapy series of conferences shows a recent focus on the importance of research.

Key Words and Terms

action stage of need satisfaction cycle
antideterministic
avoiding intellectualizations
awareness stage of need satisfaction cycle
being confrontational
being directive
blockages
body armor
cliché layer
closure
collectivism
conditions of worth
confluence
contact
curiosity
deflection
desensitization
dialogue game
dream work
Eastern philosophy
ego boundary
ego hunger and aggression
egotism
empathy
empty chair technique
environmental support
Esalen Institute
exaggeration technique
existentialism
experiencing the present
experimenting in Gestalt therapy
explosive/authentic layer
feeding the client a sentence
figure/ground
focusing on nonverbal behaviors
foreground
Gestalt
Gestalt Institute of Canada
Gestalt Institute of New York
Gestalt psychology
here and now
here and now language
hi context
holism
humanistic approach
I have a secret
I take responsibility for that
I-It language
impasse layer
impasses
implosive layer
indirect communication inhibition
intellectualizations
intercultural communication (icc)
introjection
I-Thou communication
making statements out of questions
making the rounds
Mendocino State Hospital
mindfulness
mobilization stage of need satisfaction cycle
need fulfillment
need satisfaction cycle
need identification
not gossiping
now language
Now = experience = awareness = reality
phenomenology
playing the projection
polar opposites
polarities
projection

psychodrama
repression
resistances
responsibility
retroflection
role-playing or phony layer
satisfaction stage of need satisfaction cycle
self
self-support
shouldisms
there and then language
topdog
underdog
unfinished business
void, the
withdrawal stage of need satisfaction cycle
Zen Buddhism
zero point of need satisfaction cycle

Key Names

Buber, Martin
Ellis, Albert
Friedlander, Sigmund
From, Isadore
Fromm, Eric
Fromm, Marty
Goldstein, Kurt
Goodman, Paul
Hall, Edward
Hefferline, Ralph
Horney, Karen
"Lucy"
Moreno, Jacob
Perls, Amelia Rund
Perls, Else
Perls, Fritz
Perls, Grete
Perls, Nathan
Perls, Renate
Perls, Steve
Posner, Lore "Laura"
Reich, Wilhem
Tillich, Paul

CREDITS

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7 Person-Centered Therapy

Learning Goals

At the conclusion of the chapter, readers will:

- gain a biographical understanding of Carl Rogers and the historical context in which he created his theory
- understand the antideterministic, existential, and phenomenological perspective of Rogers's view of human nature and examine how the following concepts fit his understanding of the person: the organismic valuing process, the need for positive regard, conditions of worth, incongruence or nongenuineness, defense mechanisms, and anxiety
- learn key concepts of person-centered counseling, including the actualizing tendency, the need for positive regard, conditions of worth, nongenuineness and incongruence, the organismic valuing process, choice and free will, self-determination, nondirective counseling, and the necessary and sufficient conditions
- examine the importance that the counselor qualities of congruence or genuineness, unconditional positive regard, and empathy have and how they are applied in the counseling relationship
- describe the therapeutic process of person-centered counseling and how the client increasingly moves toward expanding self-awareness, openness, and autonomy
- be able to discuss how person-centered therapy can be useful for culturally diverse clients and social advocacy as well as when it may be inappropriate for work with clients of marginalized statuses
- examine Rogers's early research using the Q-sort technique, which looked at the difference between the client's self-concept and the client's ideal self-concept; discuss the importance of empathy in therapeutic outcomes; and highlight when person-centered counseling is likely to be most beneficial

This last chapter in the section on existential-humanistic approaches presents the life and substantial impact of Carl Rogers and his person-centered approach to therapy. This chapter examines the view of human nature and key concepts of person-centered therapy; commonly used techniques and its therapeutic process; social, cultural, and spiritual considerations; and efficacy research regarding the practice of person-centered therapy. We conclude the chapter by applying person-centered principles to Angela, a member of the Miller family.

Carl Rogers

> In the past few years, I have found myself opening up to much greater intimacy in relationships. I see this development as definitely the result of workshop experiences. I am more ready to touch and be touched, physically. I do more hugging and kissing of both men and women. I am more aware of the sensuous side of my life. I also realize how much I desire close psychological contact with others. I recognize how much I need to care deeply for another and to receive that kind of caring in return. I can say openly what I have always recognized dimly: that my deep involvement in psychotherapy was a cautious way of meeting this need for intimacy without risking too much of my person. Now I am more willing to be close in other relationships and to risk giving more of myself. I feel as though a whole new depth of capacity for intimacy has been discovered in me. This capacity has brought me much hurt, but an even greater share of joy. (Rogers, 1980, pp. 83–84)

Today, many years since his death, *Carl Rogers*'s collected works and the way he lived his life continue to inspire. As the preceding paragraph from his book *A Way of Being* exemplifies, even well into his late seventies, he continued to grow and change and willingly take risks toward the development of deeper intimacy. He was a person who lived his theory: a theory he believed was both a way of being for himself, with clients and with all people. We can only hope his impact on us is such that it makes us more of a risk-taker as well as a person who can increasingly love, care, and be real with others—qualities he repeatedly stated were critical elements to living in the world. But how did this man become one of the most important social scientists of the 20th century? Let's take a look.

FIGURE 7.1 Carl Rogers

Born on January 8, 1902 in a Chicago suburb, Rogers was eventually recognized as the most influential psychologist of all time (Cook et al., 2009; Simon, 2007). The fourth of six children, Rogers's civil engineer father and stay-at-home mother brought him up in a strict home and were parents he described as uncompromisingly religious, controlling, and, despite not being expressive with their affection, seemed to love and care for their children (Kirschenbaum, 2009; Rogers, 1961). A bright, sensitive, shy, and sickly child, Rogers developed a close relationship with his mother. His upbringing would eventually yield a young person who was an independent thinker and self-disciplined.

At the age of 12, Rogers's family moved to a farm outside of Chicago, and it is not surprising that, at 17, he left for the University of Wisconsin to major in agriculture. Given his mother's religiosity, it is also not surprising that he later switched majors to religion, thinking he would eventually become a minister. Ironically, being chosen as one of a handful of students to go to the World Student Christian Federation Conference in Beijing would have the effect of widening his perspectives, which led to him to doubt many of his religious views.

Against his parents' wishes, at the age of 22, Rogers married *Helen Elliott* and soon moved to New York City to attend Union Theological Seminary. With doubt in his mind about whether he was pursuing the correct career path, and with the school encouraging students to actively reflect on why they were considering the ministry, in 1926, Rogers left the seminary to start his master's in psychology at Columbia University. After finishing all but his dissertation, he worked as a child psychologist at the Rochester Society for the Prevention of Cruelty to Children (RSPCC), and in 1929,

he became the director of the clinic's Child Study Department. During this time, Rogers and his wife had two children, *David* and *Natalie*, and Rogers started his PhD in Clinical Psychology at Columbia. In 1931, Rogers finished his dissertation, "Measuring Personality Adjustment in Children Nine to Thirteen Years of Age." He wrote his first book, *The Clinical Treatment of the Problem Child*, in 1939.

Although initially intrigued with the psychodynamic approach to treatment, while at RSPCC Rogers became increasingly fascinated with the work of *Otto Rank*, one of Freud's favorite disciples, who later took on an *existential–humanistic* framework, which emphasized focusing on the present, free will, and having an egalitarian relationship with clients (Kramer, 1995; Rank, 1996).

> I became infected with Rankian ideas and began to realize the possibilities of the individual being self-directing. (Rogers, 1936, as cited in Krischenbaum, 1979, p. 95)

Rogers had other influences as well, such as the educational philosopher and psychologist *John Dewey* (1859–1952), who stressed the importance of reflection and experience in learning, and existentialists, such as *Søren Kierkegaard* (1813–1855), who wrote about how subjectivity affects the choices people make. He was probably also influenced by the philosophy of *Jean-Jacques Rousseau* (1712–1778), who believed people had a natural tendency to be kind, if governments could set up the environment for this to occur; Eastern philosophy and mystics; and even the modern-day views of scientists on the nature of the universe (Kirschenbaum & Henderson, 1989a). He was undoubtedly also influenced by his nondemonstrative and sometimes controlling parents. It is likely that his parents' rigidity and judgmental attitudes led him to believe in the importance of communicating feelings openly and honestly and demonstrating a warm, caring relationship with others. Although Rogers was clearly influenced by others, he also repeatedly stated that he mostly relied on his own experiences with clients for the development of his theory:

> Neither the Bible nor the prophets—neither Freud nor research—neither the revelations of God nor man—can take precedence over my own direct experience. (Rogers, 1961, p. 24)

In 1940, Rogers was offered a full professorship at Ohio State University, and in 1942, he wrote *Counseling and Psychotherapy*. It is here that we first see semblances of what became known as Rogers's *nondirective approach to counseling*—a theory that stood in stark contrast to the deterministic, authoritarian, interpretive position that Freud had taken when developing psychoanalysis:

> Effective counseling consists of a definitely structured permissive relationship which allows the client to gain an understanding of himself to a degree which enables him to take positive steps in the light of his new orientation. This hypothesis has a natural corollary, that all the techniques used should aim toward developing this free and permissive relationship, this understanding of self in the counseling and other relationships, and this tendency toward positive, self-initiated action. (Rogers, 1942, p. 18)

In 1945, Rogers took a position at the University of Chicago to establish a counseling center, and from 1946–1947 he served as president of the American Psychological Association (APA). During the 1940s, while at the University of Chicago, Rogers and *Thomas Gordon* brought counselors together in a group setting, so they could discuss problems they might encounter when working with returning GIs from World War II (Kirschenbaum, 2009; Rogers, 1970). Applying his nondirective approach to this group format, he soon found that for a good number of these therapists, self-disclosure within the group setting resulted in a deepening of expression of feeling and, in many instances, a deeper understanding of themselves. This is often seen as the precursor to the *encounter group movement* that became increasingly popular and flourished during the 1960s and 1970s.

In 1951, Rogers published a major work on his approach, *Client-Centered Therapy*, which increasingly focused on the attitudes of the therapist (Kirschenbaum, 2009). In fact, Rogers began to

avoid using the word "technique" when describing his approach, arguing that the most important therapeutic attributes were the ability of counselors to show acceptance and understanding toward their clients.

> [T]o create a psychological climate in which the client feels that kind of warmth, understanding and freedom from attack in which he may drop his defensiveness, and explore and reorganize his life style, is a far more subtle and delicate process than simply "reflecting feeling." (Rogers, 1950, as cited in Kirschenbaum, 2009, p. 156)

As Rogers's ideas took hold, many quickly adopted his use of the word "client" instead of "patient," as the word "patient" was associated with the objectification of people from the medical model (Kirschenbaum, 2009). It was also around this time that his theory became known as *client-centered counseling*. As Rogers's influence grew, therapists increasingly began to agree with Rogers's view of the person and began to trust their clients' ability to direct their own counseling sessions. This contrasted sharply with the authoritarian and interpretive approach used by psychoanalysts and the directive and reductionistic perspective of the behaviorists:

> I do not discover man to be well characterized in his basic nature by such terms as fundamentally hostile, antisocial, destructive, evil.
>
> I do not discover man to be, in his basic nature, completely without a nature, a tabula rasa on which anything may be written nor malleable putty which can be shaped into any form.
>
> I do not discover man to be essentially a perfect being, sadly warped and corrupted by society.
>
> In my experience I have discovered man to have characteristics which seem inherent in his species, and the terms which have at different times seemed to me descriptive of these characteristics are such terms as positive, forward-moving, constructive, realistic, trustworthy. (Rogers, 1957a, p. 200)

Rogers believed in the importance of showing the effectiveness of his client-centered approach, so he became progressively more involved with finding ways of researching client change. As a result, in 1956, he shared, with Kenneth W. Spence and Wolfgang Köhler, the APA's first Distinguished Scientific Contribution Award. Also in 1956, and again in 1962, Rogers held debates with *B. F. Skinner* that pitted his humanistic philosophy against Skinner's behavioral approach. Although the tapes made from the second and longest debate were originally to be distributed to the public, Skinner would not allow transcripts of them to be released (Rogers, 1980). A quarter of a century later, the transcript was finally published in Kirschenbaum and Henderson's (1989b) book, *Carl Rogers: Dialogues*. Rogers viewed the debates as a discourse on how he and Skinner came to make sense of the world and not as a discussion about whether one of them held the "truth"; "I have come to realize that the basic difference between a behaviorist and a humanistic approach to human beings is a philosophical choice" (Rogers, 1980, p. 56). He went on to say, however, that choosing one approach over the other had consequences, and as you might guess, the consequences were better if one chose the humanistic approach.

In 1957, Rogers wrote a seminal article that described the *necessary and sufficient conditions* for counseling (Rogers, 1957b). It was during this same year that he decided to return to teach at his alma mater, the University of Wisconsin. However, in 1964, after becoming disillusioned with some of the politics of higher education, he took a research position at the Western Behavioral Studies Institute (WBSI) in La Jolla, California. In this same year, he won the Humanist of the Year award from the American Humanist Association. In 1968, he left WBSI and started the Center for the Studies of the Person, which focused on humanistic education, philosophy, and counseling. It was

also during this year that the film *Journey into Self*, which showed Rogers facilitating an encounter group, won the Academy Award for feature-length documentary (Kirschenbaum, 2009).

In many ways, the 1970s was a decade of contrasts for Rogers. Becoming internationally known for the documentary, his writings, and his lecturing, Rogers was idolized by many, especially those in the mental health fields. In 1972, he won the Distinguished Contributions to Applied Psychology as a Professional Practice award of APA. At the same time, Rogers was struggling with many of his own "human" issues. In a decade of "do your own thing" and experimentation with open relationships and sexuality, Rogers, too, was getting in touch with his sexuality. Sexual intimacy between Rogers and his wife had ceased, due in part to several ailments with which Helen was battling (Kirschenbaum, 2009). Rogers contemplated going outside of his marriage for intimacy. Meanwhile, Rogers was writing a book entitled *Becoming Partners* (1972), which spoke to the importance of open and honest communication with one's partner. Wanting to be "real," Rogers shared his desires with his wife, as well as with others whom he trusted. This honesty would be very painful to Helen, and the couple struggled during much of this decade. In fact, while he was still married, Rogers fell in love with a woman much younger than himself and did have a few ongoing sexual relationships with other women, which Helen undoubtedly knew about. Despite their faltering marriage, Rogers loved Helen, as was apparent when she neared her death:

> When I went to the hospital as usual to feed her her supper, I found myself pouring out to her how much I had loved her, how much she had meant in my life, how many positive initiatives she had contributed to our long partnership. I felt I had told her all these things before, but that night they had an intensity and sincerity they had not had before. (Rogers, 1980, as cited in Kirschenbaum, 2009, p. 465)

It was also during this decade that it became evident to his son and daughter, but not to others with whom Rogers was close, that he had a drinking problem (Kirschenbaum, 2009). Drinking heavily to help him sleep at night, Rogers initially denied that alcohol was a problem; however, he later admitted that he drank too much. Sadly, alcohol was a problem that plagued Rogers until he died, although it did not seem to affect his writing or ability to work with clients.

The last years of Rogers's life were spent traveling the world making speeches, providing counseling and therapy, writing, and addressing social justice issues. Believing that his approach was a philosophy of living and that many of his concepts could be applied to all human relationships, it is not surprising that he changed the name of his approach to *person-centered counseling* and, in 1980, published one of his last books, *A Way of Being*. During the 1980s, Rogers could be found facilitating encounter groups between Protestants and Catholics in Northern Ireland, trying to pull together Black and White people in South Africa, and facilitating communication groups around the world, including what was then the Soviet Union. A different kind of peace activist, he believed that if individuals could have the opportunity to see the inner core of another person, they would realize the true essence of that person and come to understand why a person feels and acts the way they do. This understanding, believed Rogers, was critical to peaceful coexistence. Rogers had an uncanny ability to bring disparate people together and have them see one another in new and enlightened ways.

> [T]his was, after all, the essence of Rogers's life's work—not only a theoretical belief in the ideal of better communication, but an ongoing search for realistic and effective ways of implementing that theory on the intrapersonal, interpersonal, intergroup, and, in the end, international levels of application. (Kirschenbaum & Henderson, 1989c, p. 435)

In January of 1987, Rogers was nominated for the Nobel Peace Prize; however, in February of the same year he died of heart failure following surgery for a broken hip. Over his lifetime, Rogers wrote dozens of books, chapters in books, and articles expanding on this theory, with his most well-known

books being *Client-Centered Therapy* (1951), *On Becoming a Person* (1961), *Freedom to Learn* (1969), *Carl Rogers on Encounter Groups* (1970), *Becoming Partners: Marriage and Its Alternatives* (1972), *Carl Rogers on Personal Power* (1977), and *A Way of Being* (1980). In addition, two well-known books published by Kirschenbaum and Henderson (1989b, 1989d)—*Carl Rogers: Dialogues* and *The Carl Rogers Reader*—contain interesting essays that Rogers wrote and fascinating conversations that Rogers had with some of the leading intellectuals of the twentieth century. Finally, Rogers's daughter, Natalie Rogers (1928–2015), continued in her father's tradition by becoming a well-known psychologist and by founding the Person-Centered Expressive Arts Institute (see Box 7.1).

BOX 7.1 Want to Meet Carl Rogers?

Want to hear a brief biography about Rogers from the man himself and find other tidbits of information about him? Go to https://silver.odu.edu/psyadm/ to see a caricature of Rogers talking about himself and his theory. Click on the existential–humanistic door, and go into Rogers's office.

View of Human Nature

> The only reality I can possibly know is the world as I perceive and experience it at this moment. The only reality you can possibly know is the world as you perceive and experience it at this moment. And the only certainty is that those perceived realities are different. There are as many "real worlds" as there are people! (Rogers, 1980, p. 102)

Rogers had a *phenomenological perspective* on the individual, which means he believed that reality is a function of that person's consciousness or understanding of the world. And he believed that the person, not others, could best understand their experience of the world. At the same time, he believed we could come close to sensing other people's unique inner worlds (Rogers, 1957b, 1980). Like all living organisms, Rogers suggested that the infant and growing child has what is called an *actualizing tendency*, which lends directionality to lives as individuals seek to reach their unique and *full potential* (Rogers, 1951). If unimpeded, this force leads to constructive growth and healthy relationships.

As the child grows and interacts with others, Rogers stated that they engage in what is called an *organismic valuing process*, wherein individuals move toward those experiences or interactions that are positive to the actualizing process and away from those that are negative. However, Rogers also believed that as a *self* emerges, an individual develops a need for *positive regard*. Sometimes, said Rogers, this need was more compelling than the push toward a positive actualizing experience. So if a significant other (e.g., a parent) gives the individual the message that they would only be loved if certain qualities are shown, and if these qualities are antithetical to the actualizing process, the individual will forego the actualizing process and act in accordance with the wishes of the significant other. Rogers believed that when these *conditions of worth* are placed on a person, they thwart the natural growth process and result in the development of a nongenuine or incongruent way of living in the world.

Rogers believed that individuals sometimes do not perceive conditions of worth being placed on them or the resulting incongruence, and he posited that they develop a *process of defense* in which they selectively perceive situations, distort situations, or deny threats to self to protect themselves from a state of anxiety that is the result of this incongruence. The ability to defend oneself, however, is not perfect, and anxiety and related symptoms can be conceptualized as a signal to the individual that they are acting in a nongenuine way and not living fully (see Box 7.2):

> When the individual has no awareness of such incongruence in himself, then he is merely vulnerable to the possibility of anxiety and disorganization ... If the individual dimly perceives such an incongruence in himself, then a tension state occurs which is known as anxiety. (Rogers, 1957b, p. 97)

BOX 7.2 The Story of Ellen West

This story, so eloquently told by Rogers (1961), describes the history of a famous psychotherapy client (a client Rogers knew about but never saw himself). Rogers described the estrangement of this person from their feelings—how they felt obligated to follow their father's wishes and not marry the man they loved, how they disengaged themself from their feelings by overeating, and how a few years later they again fell in love but instead married a distant cousin according to their parents' wishes. Following this marriage, they became anorexic, taking 60 laxatives a day, again as an apparent attempt to divorce themself from their feelings. They saw numerous doctors, who gave them differing diagnoses, treated them dispassionately, and generally denied their humanness. Eventually, disenchanted with their life, Ellen West committed suicide.

This story, Rogers noted, gives a poignant view of what it is like to lose touch with self—to be incongruent. Because Ellen West felt they needed to gain the conditional love of their parents, they acted in ways not congruent with self. Losing touch with self led to a life filled with self-hate and a sense of being out of touch. Eventually, therapists viewed them as being mentally ill, which Rogers implied might have added to their feelings of estrangement and eventual suicide.

Rogers believed that when a person (such as a client) is with a second person who demonstrates genuineness (or *congruence*), empathy, and unconditional positive regard, the first person will feel safe enough to experience themself with all the incongruities that may have been developed as a function of conditions of worth that had been placed on that person.

Gaining awareness of the incongruent self is the first step clients take toward making choices that will lead individuals toward a more congruent self (Rogers, 1959). Calling *genuineness, empathy,* and *unconditional positive regard* the *core conditions,* Rogers believed that these attributes, alone, are enough to facilitate change and that any individual, not just counselors and therapists, can embody these characteristics to help induce change (Rogers, 1957b, 1980).

As you can probably deduce, the person-centered approach is *anti-deterministic,* as highlighted by its idea that people can understand their defensiveness, make changes in their lives, and move forward as they actualize their full potential. This belief in choice and free will lends an *existential* flavor to the person-centered approach and stands in contrast to the deterministic leanings of the psychoanalytic approach, which posits we are victims of our drives, or the behavioral approach that view reinforcement contingencies as being responsible for behaviors.

Rogers believed his approach could be adopted by many and applied in different settings, and he lived out this belief by traveling the world and meeting with disputing peoples, while applying these qualities, as he sought to bring understanding and peace to others (Kirschenbaum & Henderson, 1989e).

Key Concepts

Some of the fundamental key concepts of person-centered counseling include the actualizing tendency, the need for positive regard, conditions of worth, nongenuineness and incongruence, organismic valuing process, choice and free will, self-determination, nondirective counseling, and the necessary and sufficient conditions.

Actualizing Tendency

Rogers believed that every individual is born with an *actualizing tendency* that motivates the person to reach their full potential if the individual is placed in an environment that supports this inherent process. This basic biological principal has its corollary in all living things. For instance, consider the flower that delightfully blooms if placed in an optimum environment but ends up wilting if not. This important assumption for person-centered counselors affects how they conceptualize their clients' concerns. Instead of seeing clients from an illness perspective, they believe their clients have the potential to change and grow if placed in a nurturing environment. Such counselors view client progress as occurring when clients become increasingly real and genuine, which results in the making of better choices.

Need for Positive Regard

In their development of self, children have a *need for positive regard* by significant others—that is, to feel loved, supported, and appreciated by those close to them. In fact, children will manifest behaviors they believe those close to them would want them to exhibit in hopes that they will be positively regarded by them, even if those behaviors are antithetical to the individual's natural way of being. In this case, the exhibition of such behaviors creates a false or nongenuine self. When this occurs, conflict exists between the individual's actualizing tendency and their need to be positively regarded and loved by significant others.

Conditions of Worth

Closely related to the need to be positively regarded are *conditions of worth* that occur when significant others, who have the power to withhold their love and regard, place expectations on a person's way of responding. In this case, significant others are expecting an individual to respond in a certain manner, even if that type of response is not how the person wishes to respond. Love, or the promise of love, is withdrawn if the person does not respond in that manner, and love is given if the person does respond in that manner (although one might argue that anyone who uses "love" as a bargaining chip is not really loving). Over time, the individual learns to respond in the way the significant other wants them to respond, even if that response is not natural or true to self. The dilemma for children is whether to listen to their internal state, which tells them to respond in a certain manner, or to exhibit behaviors to gain love and regard from significant individuals. Consider Figure 7.2, and then read Box 7.3.

BOX 7.3 Struggling With Conditions of Work

Figure 7.2 shows a mother placing conditions of worth on her daughter. In what other ways could this mom have responded? Consider your childhood. What conditions of worth were placed on you? How could your parents or significant others have responded differently? What impact did conditions of worth have on your life?

Nongenuineness and Incongruence

Nongenuineness, sometimes called *incongruence*, is a product of conditions of worth being placed on the individual, as the individual acts in ways that do not match their natural state of being. An individual who is nongenuine is not in touch with some, or even a majority, of their feelings. In addition, their thoughts, feelings, and behaviors are incongruent; that is, the individual's feelings are not in sync with their thoughts and behaviors.

FIGURE 7.2 A Mother's Condition of Worth

Organismic Valuing Process

The process of drifting toward individuals who positively value one's natural tendencies or ways of being, or drifting away from those who negatively value them, is called the *organismic valuing process*. The validation of a person's inherent or natural ways of living in the world leads to a positive self-image. However, when conditions of worth are placed on an individual, the individual's organismic valuing process is thwarted as the individual acts falsely, or in nongenuine ways, to gain the love of another (see Box 7.4).

BOX 7.4 A Young Boy's Need for Regard and Development of Self

A young boy exhibits what some might call traditional feminine behaviors to which the boys' parents respond, in verbal and nonverbal ways, that this behavior is unacceptable (conditions of worth). Because their need to be loved by his parents outweighs their actualizing tendency, they end up living a nongenuine life as they try to adapt and act as their parents want them to act. Although most of this occurs slightly outside of their awareness, as they grow into their teenage years, they experience an internal tug that something is not right. As they become older, they continue to feel some subtle generalized anxiety—a sign that something is not right. As they grow into adulthood and have more distance from these early experiences, they continue to feel as if something is off kilter in their life. It is at this point that they enter therapy and find a therapist as well as significant others in their life, who demonstrate qualities that allow their true self to emerge. After years of living a false life, they slowly become their true self—again!

Choice and Free Will

> Nevertheless it has meaning for me that the more the person is living the good life, the more he will experience a freedom of choice, and the more his choices will be effectively implemented in his behavior. (Rogers, 1961, p. 193)

As a phenomenologically based, existential theorist, Rogers believed that people have *free will* to make *choices* based on their subjective view of reality. However, he also acknowledged that individuals are victims of their pasts, especially when they are living lives based on a false, incongruent sense of self. In these cases, decisions are grounded in an individual's defenses and distortions and often result in unhealthy choices. In contrast, individuals who are fully functioning and congruent are burdened less by defenses, determined little by their past, and have freedom of choice. These individuals are in touch with and are aware of their feelings, thoughts, and behaviors; have a clear sense of which choices enhance their well-being; and will make choices congruent with their true selves. Such choices will be so clear that it will almost seem as if there is no choice!

Self-Determination

In person-centered counseling, *self-determination* is the process of looking within to make choices about oneself, as opposed to allowing others to direct one's life. Incongruent clients will be out of touch with who they are and make poor choices for themselves or look for answers outside of themselves. Such clients are sometimes said to have an *external locus of control*. Thus, Rogers stressed the importance of creating an environment that will allow clients to be more in touch with themselves and, ultimately, make choices from an inner sense of who they are and less from the advice of others. In this process, clients move from dependency to autonomy as they gain a greater *internal locus of control*, or a sense that their destiny is in their own hands.

Nondirective Counseling

Rogers believed the ingredients for self-discovery lay within each person and encouraged counselors and therapists to offer a counseling environment facilitative of self-discovery, as opposed to one that was directive, advising, or interpretative. By counselors providing a *nondirective counseling* stance using empathy, genuineness, and unconditional positive regard, he suggested that clients would feel free to look inside themselves, discover their inner world, become increasingly in touch with their true selves, and make self-initiated positive and growth-producing choices.

The Necessary and Sufficient Conditions

Rogers believed that personality change would occur if the therapeutic framework included six *necessary and sufficient conditions*:

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is, to a minimal degree, achieved. (Rogers, 1957b, p. 96)

If the above six conditions were met, Rogers suggested that the following changes would often occur with clients (Rogers, 1959, 1961):

- an increased openness to experience
- a greater ability to be more objective and to have more realistic perceptions
- improved psychological adjustment
- more congruence, increased self-regard, and movement from an external to an internal locus of control
- more acceptance of others
- having better problem-solving skills
- having a more accurate perception of others

But what about clients who are difficult to reach? Would change occur with them? Admitting that some clients would certainly be more difficult to connect with than others, Rogers believed that it was crucial for therapists to try and connect; otherwise, as noted in step 6, the necessary and sufficient conditions would be for naught. Look at Box 7.5 to see how Rogers connected with a client who is living with schizophrenia.

BOX 7.5 Rogers's Work With a Man With Schizophrenia

Demonstrating how his conditions of worth are critical with any person, even a person who is difficult to reach, Rogers gives the example of his work with an individual with schizophrenia:

> I think of one man with whom I have spent many hours, including many hours of silence. There have been long stretches when I had no way of knowing whether the relationship had any meaning for him. He was uncommunicative, seemingly indifferent, withdrawn, inarticulate. I think of an hour when he felt completely worthless, hopeless, suicidal. He wanted to run away, wanted to do away with himself because, as he muttered in flat despair, "I just don't care." I responded, "I know you don't care about yourself, don't care at all, but I just want you to know that I care." And then, after a long pause, came a violent flood of deep, wracking, gasping sobs which continued for nearly half an hour. He had taken in the meaning of my feeling for him. It was dramatic evidence of what all of us have learned—that behind the curtains of silence, and hallucination, and strange talk, and hostility, and indifference, there is in each case a person, and that if we are skillful and fortunate we can reach that person, and can live, often for brief moments only, in a direct person-to-person relationship with him. To me that fact seems to say something about the nature of schizophrenia. It says something too about the nature of man and his craving for and fear of a deep human relationship. It seems to say that human beings are persons, whether we have labeled them as schizophrenic or whatever. And I know that these moments of real relationship with these persons have been the essential reward for all of us participating in the program. (Rogers, 1967, pp. 191–192)

Carl R. Rogers and Barry Stevens, "Selections," *Person to Person: The Problem of Being Human*, pp. 191-192, 186. Copyright © 1967 by Real People Press. Reprinted with permission.

Therapeutic Techniques

Believing that the word "technique" detracted from the essence of the personal relationship that occurred within counseling, Rogers rarely used that word (Kirschenbaum, 2009). However, he often elaborated on the three personal qualities he believed counselors should embody if they were to be effective in the helping relationship: congruence, unconditional positive regard, and empathy.

Congruence or Genuineness

For Rogers, *congruence, genuineness*, or being real within the context of the therapeutic relationship was the most important of the therapeutic qualities, as a relationship has no meaning if the counselor hides behind a mask, unwilling to risk being themself:

> It is when the therapist is natural and spontaneous that he seems to be most effective. Probably this is a "trained humanness" as one of our therapists suggests, but in the moment it is the natural reaction of this person. Thus our sharply different therapists achieve good results in quite different ways. For one, an impatient, no-nonsense, let's-put-the-cards-on-the-table approach is most effective, because in such an approach he is most openly being himself. For another it may be much more gentle, and more obviously warm approach, because this is the way this therapist is. Our experience has deeply reinforced and extended my own view that the person who is able openly to be himself at that moment, as he is at the deepest levels he is able to be, is the effective therapist. Perhaps nothing else is of any importance. (Rogers, 1967, p. 186)

But what if a therapist has particularly strong negative or positive feelings toward a client or feelings that are, as Rogers (1957b) described, mysterious, threatening, or frightening? At the very least, Rogers said, the counselor needs to be in touch with and aware of those feelings and sometimes talk them out with their client or others.

> Certainly the aim is not for the therapist to express or talk out his own feelings, but primarily that he should not be deceiving the client as to himself. At times he may need to talk out some of his own feelings (either to the client, or to a colleague or supervisor) if they are standing in the way of the two following conditions [empathy and unconditional positive regard]. (Rogers, 1957b, pp. 97–98)

The level of self-disclosure the therapist shows the client, however, may vary depending on the session and whether the feeling is persistent. Rogers noted that although one may have negative feelings toward a client during a session, these feelings will almost invariably dissipate as the client opens up and unravels their inner self. Therefore, he warned therapists against using excessive self-disclosure. Finding the balance between the counselor's awareness of their own feelings and the expression of those feelings in an effort to be real is one of the challenges facing the person-centered therapist (see Box 7.6).

BOX 7.6 Being Genuine and Timing Self-Disclosure

I (Neukrug) remember working with a client who was in a very unhappy and verbally abusive relationship. Every week, she would come in and tell me how horrible her partner was. Thinking she could easily leave this person, I began to feel frustrated. Then, one day, after telling the same story for the umpteenth time, she began to open up and describe how fragile she felt and how fearful she was to be on her own. She was afraid of her loneliness, afraid that she would start drinking heavily, and afraid that she might have a "nervous breakdown." It was soon after this disclosure that she had the courage to leave. Perhaps, if I had expressed my frustration about her situation earlier, she would have responded more to my feelings about her situation and never had gotten in touch with her feelings that were so important for her to understand. Being real in a helping relationship is important, but being real at the right moment is essential.

Unconditional Positive Regard

Rogers believed that counseling relationships should be highlighted by a sense of acceptance, regardless of what feelings are expressed by the client. In other words, the counselor should not accept certain feelings and experiences of the client and deny others. This unconditional acceptance, or responsible love, allows the client to feel safe within the relationship and delve deeper into themself (Buscaglia, 1996). This type of acceptance recognizes that the client is acting in the only way they can behave at this time in their lives.

As the client begins to take steps toward understanding this deepening self, they will understand those aspects of self that are false and those that are real. In other words, the client will begin to see how they are living a false life as the result of past conditions of worth that were placed upon them. Although Rogers states that *unconditional positive regard* should be present for the totality of a session, he admits that this is the ideal and suggests that all therapists must continually strive to achieve this state of being (see Box 7.7).

BOX 7.7 I Guess Nobody Is Perfect—Not Even Dr. Rogers

Hear this story (entitled "Oh My God, He Doesn't Like Me") and other stories about Carl Rogers by clicking Carl Rogers at the Stories of the Great Therapists website: http://www.odu.edu/sgt.

In the late 1970s, I (Neukrug) went to hear Carl Rogers talk for my second time. I was excited—Rogers was my hero. There were thousands of people in the audience, and as he fielded questions, I shyly raised my hand. Suddenly, he was pointing at me. I stood up and blurted something out, at which point he asked me to repeat myself. I tried to reformulate my question, and he said something like, "I can't understand what you're talking about." He moved on to another question. I was shattered, hurt, and wanted to roll up into a ball. And he—yes, Carl Rogers—had not been as caring as he could be to this young counselor. I then discovered that even our heroes are not perfect and no one person can constantly demonstrate unconditional positive regard.

Empathy

Perhaps the most researched and talked-about element of the counseling relationship, *empathy*, or deep understanding of the client, was Rogers's third crucial element in the helping relationship

(Rogers, 1957b). Such understanding can be shown in several ways, including accurately reflecting the meaning and affect (feelings) of what the client expressed; using a metaphor, analogy, image, or self-disclosure to show the client that they were accurately heard; simply nodding one's head or gently touching the client during the client's deepest moments of pain; and in other ways. Such acknowledgment of the client's predicament communicates to the client that the therapist has experienced their inner world:

> To sense the client's private world as if it were your own, but without ever losing the "as if" quality—this is empathy, and this seems essential to therapy. To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it, is the condition we are endeavoring to describe. When the client's word is this clear to the therapist, and he moves about in it freely, then he can both communicate his understanding of what is clearly known to the client and can also voice meanings in the client's experience of which the client is scarcely aware. (Rogers, 1957b, p. 99)

Over the years, Rogers's explanation of empathic listening has been interpreted and often packaged into what many of us now call *reflection of feelings*, or parroting what the client said (Kylie, 2014). In one of the last articles written by Rogers, he voiced anger toward some of the ways in which his concept of empathic understanding had been interpreted. Noting the use of the terms "reflection of feeling" and "parroting" of client statements, Rogers stated that he never meant the counselor to mimic what the client had said but to use all avenues to show the client that the counselor understood their way of making meaning out of the world.

> From my point of view as therapist, I am not trying to "reflect feelings." I am trying to determine whether my understanding of the client's inner world is correct, whether I am seeing it as he or she is experiencing it at this moment ... Am I catching just the color and texture and flavor of the personal meaning you are experiencing right now? (Rogers, 1986, p. 376)

Rogers noted that some of the best empathic responses to a client are those in which the therapist can *subceive* feelings beyond those of which the client is aware (Rogers et al., 1967). As opposed to interpreting feelings that the therapist thinks the client might be having, subceiving feelings means that the therapist is sensing deep feelings from the client, feelings of which the client may not be aware. Only when the client agrees that they are experiencing these feelings is the therapist "on target" with their response.

Basic Applications of Empathic Responding

The popularity of Rogers's ideas during the 1950s and 1960s naturally led to several operational definitions of empathy. For instance, Truax and Mitchell (1961) developed a nine-point rating scale to measure empathy, which was later revised by Carkhuff (1969) into a five-point scale. A scale to measure empathy had important implications. For the first time, researchers could measure the empathic ability of counselors and determine whether there was a relationship between good empathic responses and client outcomes in therapy. Indeed, numerous research studies indicated that good empathic ability was related to progress in therapy (Elliott et al., 2018; Wampold, 2019; Wampold & Budge, 2012; Wampold & Imel, 2015).

Believing that scales like this focused too much on "technique" at the expense of focusing on how the professional brought themself into the relationship, Rogers was ambivalent about the development of such instruments (Kirschenbaum, 2009). Despite Rogers's mixed feelings, the *Carkhuff Accurate Empathy Scale* became a mainstay of counselor training during the 1970s and

1980s, and although it is no longer used as extensively, the scale set the stage for *microcounseling skills training* methods in counseling programs (Ridley et al., 2011; Egan & Reese, 2019; Ivey et al., 2018). The scale ranges from a low of 1.0 to a high of 5.0 with 0.5-point increments. Any responses below a 3.0 were considered *subtractive empathy* or nonempathic, while responses of 3.0 or higher were considered empathic with responses over 3.0 called *additive empathy* responses (see Figure 7.3).

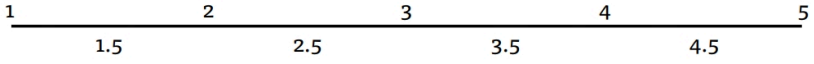

FIGURE 7.3 The Carkhuff Accurate Empathy Scale

The original Carkhuff Accurate Empathy Scale, reproduced in Table 7.1, dramatically changed the education of helping professionals, as professors, students, and helpers could assess one another's ability to make an empathic response. A level-1 or level-2 response, in some ways, detracts from what the person is saying (e.g., giving advice, not accurately reflecting feeling, and not including content), with a level-1 response being way off the mark and a level-2 being only slightly off. For instance, suppose a client said, "I've had it with my dad; he never does anything with me. He's always working, drinking, or playing with my little sister." A level-1 response might be, "Well, why don't you do something to change the situation, like tell him what an idiot he is?" (i.e., advice-giving and being judgmental). A level-2 response might be, "You seem to think your dad spends too much time with your sister" (i.e., does not reflect feeling and misses content). On the other hand, a level-3 response, such as "Well, it sounds as though you're pretty upset at your dad for not spending time with you," accurately reflects the affect and meaning of the client.

TABLE 7.1. Carkhuff's Accurate Empathy Scale

Level 1	The verbal and behavioral expressions of the first person either do not attend to or detract significantly from the verbal and behavioral expressions of the second person(s) in that they communicate significantly less of the second person's feelings than the second person has communicated themself.
Level 2	While the first person responds to the expressed feelings of the second person(s), they do so in such a way that they subtract noticeable affect from the communications of the second person.
Level 3	The expressions of the first person in response to the expressed feelings of the second person(s) are essentially interchangeable with those of the second person in that they express essentially the same affect and meaning.
Level 4	The responses of the first person add noticeably to the expressions of the second person(s) in such a way as to express feelings a level deeper than the second person was able to express themself.
Level 5	The first person's responses add significantly to the feeling and meaning of the expressions of the second person(s) in such a way as to (a) accurately express feelings below what the person themself was able to express or (b) in the event of ongoing, deep self-exploration on the second person's part, to be fully with him in their deepest moments.

Note. From *Helping and human relations* (Vol. 2), by R. Carkhuff, 1969, p. 121.
R. Carkhuff, "Carkhuff's Accurate Empathy Scale," Copyright © 1969 by Holt, Rinehart and Winston.

Level-4 and level-5 responses reflect feelings and meaning beyond what the person is outwardly saying and adds to the meaning of the person's outward expression. For instance, in the above example, a level-4 response might be, "It sounds as though you're pretty angry at your dad because he doesn't pay any attention to you" (i.e., expresses a new feeling, anger, which the client did not outwardly state). Level-5 responses are usually made in long-term therapeutic relationships by expert therapists. They express to the client deep understanding of the pain they feel as well as recognition of the complexity of the situation.

In the training of helpers, it is usually recommended that they attempt to make level-3 responses, as a large body of evidence suggests that such responses can be learned in a relatively short amount of time and are beneficial to clients (Carkhuff & Beniot, 2019; Schaefle et al., 2005). Effective empathic responses not only accurately reflect content and feelings but do so at a moment when the client can hear this reflection. For instance, you might sense a deep sadness or anger in a client and reflect this back to them. However, if the client is not ready to accept these feelings, then the timing is off, and the response is considered subtractive.

Often, when first practicing empathic responding, beginning counselors are recommended to begin by making what is called a *formula response*, which generally starts with reflection of feeling followed by the paraphrasing of content. As beginning helpers become more comfortable with the formula response, they move to what some call a *natural response*, which embodies all the components in the formula response (reflection of feelings and content) but does so in a manner that is natural to them. So, "It sounds like you're feeling sad because you're not closer to your dad" becomes, "You really seem to be struggling with sadness about the distance you feel from your father."

Advanced, Creative, and Novel Approaches to Empathic Responding

There is an old joke concerning a fictitious dialogue between Rogers and a client that goes something like this:

> Client: I'm feeling really depressed.
>
> Rogers: So it sounds like you're feeling really depressed.
>
> Client: I'm feeling so depressed that I think I might harm myself.
>
> Rogers: I'm hearing you say that you're feeling so depressed that you think you might harm yourself.
>
> Client: In fact, I'm feeling so awful that I might just jump out that window over there.
>
> Rogers: Hmmmm ... You're feeling so awful you might just jump out that window.
>
> Client: Yes, I'm walking over to the window now.
>
> Rogers: I hear you; you're walking over to that window now.
>
> Client: I'm on the ledge.
>
> Rogers: Yes, I see you're on the ledge.
>
> Client: I'm going to jump.
>
> Rogers: You're going to jump.
>
> Client: Ahhhhhhhhhhhhhhhhhhhhhhhhh!
>
> (The client jumps.)
>
> Rogers: Ahhhhhhhhhhhhhhhhhhhhhhhh.

Well, let's start with a strong statement that the person-centered counseling approach does not encourage the kind of parroting that is highlighted above. And as stated earlier, Rogers was outspoken about the fact that being with a client involved much more than simply reflecting feelings. Although the Carkhuff Accurate Empathy Scale and other related training models of empathy are effective at teaching basic empathy responses, other more involved empathic responses have been developed over the years (Neukrug, 2017; Neukrug et al., 2013).

As counselors become more adept at making natural responses, they may begin to use what are called *advanced, creative, and novel approaches to empathic responding*, which include such responses as (a) reflecting nonverbal behaviors, (b) reflecting deeper feelings, (c) pointing out conflictual feelings and thoughts, (d) using visual imagery, (e) using analogies, (f) using metaphors, (g) using targeted self-disclosure, (h) reflecting media, (i) using tactile responses, and (j) discursive empathy (reflecting cultural and historical factors that maybe impact a person). We suggest that one first become proficient at making level 3-responses before tackling advanced, creative, and novel approaches. However, these approaches are interesting and bring breadth and depth to the counseling relationship. Here are a few examples:

- **reflecting non-verbal behaviors:** To a client who walks into your office, head down and slouched over, the counselor says, "Wow, I can tell by your body language that things are not going well."
- **using an analogy:** To the client who reveals they are struggling and trying hard to make changes, but no matter what they do things seem to be as bad as ever, could get a response like, "Sounds like you're rearranging deck chairs on the Titanic."
- **reflecting deeper feelings:** To a client who is angry that their son has decided not to go to college, a counselor might sense another feeling from them and say: "I guess I sense how disappointed you feel that your son is not going to college and what an expectation you had for him."
- **using targeted self-disclosure:** To a client who just broke up with their partner and is devastated and feels little hope for the future, the counselor might say: "I remember when I had a breakup and how I felt like the world was going to end—I imagine that's how you must feel."
- **making a tactile response:** To a client who is struggling with a hurtful and abusive spouse, a counselor might say: "You know, as you're talking, I feel like my stomach is twisting and turning; I wonder if you might be feeling similarly."
- **reflecting media (and using a metaphor):** To the client who finally feels some hope in their life, after struggling for months, the counselor might say: "As you talk, it reminds me of the song 'Here Comes the Sun'—there is finally some light in your life."
- **discursive response:** To the client who seems to feel like the world is out to get them, a counselor might say, "As a Black person, you've experienced oppression your whole life, and in fact, such oppression has harmed African American people for years; I can see that it really has impacted how you feel in general."

A lot more could be said about these advanced, creative, and novel responses; however, since they take time and patience to learn, we will leave them for now. I encourage you to practice your basic empathy skills, and if you get a chance, look further into these types of responses as they add a dimension to counseling that is exciting and interesting.

The Counseling Process

The ability of a counselor to demonstrate the above "techniques" of empathy, genuineness, and unconditional positive regard is a critical step toward developing the six necessary and sufficient

conditions of therapy. Ultimately, such conditions enable the client to feel safe enough to reveal deeper parts of self and, over time, realize how they has lived a nongenuine life due to conditions of worth. Rogers found that when the necessary and sufficient conditions were demonstrated, there was a tendency for therapy to take place in a series of steps that approximated the following order (Rogers, 1942):

1. The client comes in for therapy, which is an important, responsible action the client takes in changing their life.
2. The helping relationship is defined by the counselor as one in which the counselor does not have the answer but can offer the client a safe place where they can explore the self and find solutions to their problems.
3. The counselor provides a space where the client feels free to express all feelings regarding their problems.
4. As the client experiences the sense that they are free to express all feelings, negative feelings that the client has been fearful of acknowledging will arise, are accepted by the counselor, and can be examined.
5. After the client has expressed and processed negative feelings, positive feelings will begin to arise. These feelings, which seemed almost hidden by the negative feelings, are sometimes a surprise for clients.
6. As with the earlier negative feelings, the positive feelings that arise will also be accepted, examined, and processed.
7. The exploration of all feelings within an accepting environment leads to an understanding and acceptance of self.
8. As counseling continues, increased insight is achieved, and possible courses of action are decided.
9. The client begins to make small but important positive behavioral changes in their life.
10. Insight is expanded, and self-understanding becomes more complete and more accurate.
11. The client increasingly self-directs their life and becomes less fearful about making choices that will lead to more productive relationships and more effective behaviors.
12. The client becomes increasingly autonomous and gradually develops a sense that the therapist is no longer needed. Counseling winds down.

When originally developed, person-centered counseling was considered a short-term approach in comparison to the, then, widely popular psychodynamic methods. Whereas the expectation in many psychodynamic approaches was that the client needed to work on deep-seated issues that would take a considerable amount of time, no such expectation was placed on clients who participated in the person-centered approach. In fact, in person-centered counseling, it was often just as usual to find some clients spending only a few sessions in counseling as it was to find clients spending years in counseling. Although the principles of person-centered counseling can be applied if you meet with a client once or for five years, today, person-centered counseling generally lasts from a few sessions to a year or more. The most important determining factors in the length of treatment are likely the level of incongruence in the client and the kinds of issues the client is bringing to treatment. Finally, due to the popularity of person-centered counseling, as well as the research that indicates that empathy, genuineness, and unconditional positive regard are critical to positive client outcomes, many therapies have integrated these skills within their approach.

Social, Cultural, and Spiritual Issues

Counselors have utilized person-centered therapy across diverse populations and geographic locations (Quinn, 2012; Swan & Ceballos, 2020). The goals of a person-centered counselor remain constant, regardless of client background, orientation, or presenting concern (Cornelius-White, 2016). A person-centered counselor aims to offer genuineness, empathy, and unconditional positive regard in all relationships with clients. The way these elements are expressed and contextualized within each counseling relationship may vary between clients and contexts, depending on individual needs and experiences.

Being a culturally responsive counselor calls upon individuals to understand the client's worldview and engage in skills and interventions that empower and advocate for their well-being in an environment that can be particularly harmful for clients of color and other marginalized statuses (Ratts et al., 2015). The principles of person-centered therapy can support culturally responsive practice, given its focus on fostering the core conditions of congruence, unconditional positive regard, and empathy. For clients of marginalized statuses, however, environmental factors can act as oppressive forces and make it more challenging to reach their full potential. Because of pervasive social injustices, external factors can restrict client's conditions of worth and self-concept. Thus, social advocacy within and outside of counseling is imperative for counselors and not something that is readily practiced by the traditional person-centered counselor (Swan & Ceballos, 2020).

Swan and Ceballos (2020) offer several recommendations for using a social justice framework within person-centered therapy. We summarize them as follows:

- Gain knowledge of clients' cultural settings and real-world experiences, allowing them to define mental health,
- Establish a therapeutic relationship, and convey genuineness throughout the therapeutic process, in which the client and counselor share power and client is expert of their experiences,
- Using unconditional positive regard and empathy, foster a therapeutic alliance, so the client can feel safe to experience or process incongruence between internal self-concept and external lived experiences,
- Foster client self-acceptance by encouraging an alignment between their internal self-concept and outwardly expressed self (e.g., lived experiences) in a way their internal, organismic valuing system is strengthened,
- Be aware of how intersectionality (i.e., the way in which a client's multiple cultural identities intersect to inform their worldview and societal experiences) influences the therapeutic alliance,
- Allow clients to define what self-actualization is from the perspective of their cultural background (e.g., collectivism versus individualism),
- Understand how external systemic barriers (e.g., discriminatory policies, racial profiling, and stereotyping) affect clients,
- Process with clients how privilege and oppression experiences impact their progress toward psychological growth, and
- Account for how the impact of privilege and oppression experiences and statuses affect the client's development of self-concept and natural self-actualizing tendencies.

Relative to religion and spirituality, person-centered counselors attend to the religious and spiritual beliefs of clients as they would any other values and beliefs one might embrace, struggle with, and churn over. The effective person-centered counselor would allow any individual, whether they be Muslim, Christian, Jew, Hindu, atheist, or agnostic, to struggle over their own meaning of religion and spirituality and would allow that person to come to their own conclusion about what it means in their life.

Although congruence, unconditional positive regard, and empathy are important in any counseling relationship (Norcross & Lambert, 2018; Wampold & Imel, 2015), relying solely on their use may not be effective for every client. So when does it work, and when should one try something else? Based on some evidence, one should be wary, or at least careful, when applying a person-centered approach under the following circumstances (Al-Thani, 2012; Campbell, 2018; Kim, 2018; Neukrug et al., 2013; Quinn, 2012; Swan & Ceballos, 2020; Watt & Panksepp, 2016):

- **when the client is from a culture that extols external advice and eschews an internal locus of control.** When clients come from cultures in which religious scripture, moral truths, societal values, advice from others, or parental dictates are more important than the self in one's decision-making process, that client may be less likely to be introspective, as the values inherent in the self may counter those from their culture.
- **when therapy needs to be brief and focused.** Although many of the therapeutic qualities Rogers recommends can be used in brief therapy, if therapeutic movement needs to occur quickly, using a pure person-centered approach may simply take too long, as the counselor allows the client to self-direct the sessions and would not push the client toward predetermined goals.
- **when being in touch with feelings is frowned upon within the client's culture.** Because empathy relies on helping clients access feelings, and because some cultures downplay the importance of the expression of feelings, the use of empathy can frighten some clients and be off-putting to the therapeutic experience.
- **when the presenting problem does not lend itself to the person-centered approach.** Some problems, such as depression, respond particularly well to the core conditions of empathy, congruence, and unconditional positive regard. On the other hand, other issues, such as phobias, might be helped more quickly using other techniques.
- **when the counselor's cognitive complexity is not evolved.** Counselors who think in complex ways and view the world from multiple perspectives are more likely to be good at expressing empathy, showing unconditional positive regard, working with minority clients, and helping clients who have uncommon or difficult problems. However, counselors who are dualistic and unable to take on multiple perspectives may lack empathy and unconditional positive regard and have difficulty understating a client's situation.
- **when the cultural competence of the counselor is lacking.** As with cognitive complexity, lack of cultural competence will prevent counselors from being fully with their clients and hinder the ability to show empathy.

Further considerations and extended discussions related to multiculturalism, advocacy, and social justice issues are needed in person-centered therapy research and practice. With this in mind, Fuertes and Nutt Williams (2017) note that counselors should conduct further research on how clients deal with ambivalence and resistance, how they come to understand and express their hopes and desires, how they discuss and work through issues related to racism and marginalization, how they develop coping mechanism as they advance in counseling, and how they come to understand and express issues related to their religious and spiritual beliefs. Despite some of the cautions we provide above, person-centered therapy has multiple benefits to address the social, cultural, and spiritual issues that most clients face as they seek a positive self-concept and overall well-being.

Efficacy of Person-Centered Counseling

During the 1940s and 1950s, Rogers became increasingly interested in showing the effectiveness of the client-centered approach. His interest resulted in the attainment of a series of grants that

would allow Rogers and his staff at the University of Chicago Counseling Center to be some of the first researchers to examine client change (Kirschenbaum, 1979, 2009). The researchers completed a series of experimental studies, with control groups, that included the use of what was called the Q-sort technique. Using this technique, the researchers examined a wide range of outcomes related to what was then called client-centered counseling. In particular, they found that client-centered counseling had success at reducing the gap between how clients actually saw themselves (their *self-concept*) and how they wanted to be (their *ideal self-concept*). Although criticized as being methodologically weak by some, this research was seen as groundbreaking, as it was the first to use client self-report as well as client tapes and transcripts of sessions to examine client change.

Regardless of the background of the client, the most important quality for positive therapeutic outcomes is the therapeutic alliance, or the ability of the counselor to connect with the client (Hilsenroth, 2014; Wampold, 2010, 2019; Wampold & Budge, 2012; Wampold & Imel, 2015). Supporting the importance of the therapeutic alliance, Gelso and colleagues (2019) note that the alliance affects the counseling relationship from the moment the client starts their first session until the client terminates counseling, regardless of whether it is acknowledged by the counselor and the client. Recent research on therapy outcomes, common factors, the working alliance, and therapeutic relationships has provided support for Rogers's core conditions—empathy, unconditional positive regard, congruence—being critical components of effective psychotherapy (Farber et al., 2018; Kirschenbaum & Jourdan, 2005; McClintock et al., 2018; Ribeiro et al., 2014).

In addition to research on the therapeutic alliance, research that specifically focuses on the use of empathy has shown it to be one of the most critical factors for effective client outcomes (Elliot et al., 2018; Laska et al., 2014; Norcross & Lambert, 2018; Watson, 2016; Winburn et al., 2020). However, the use of empathy may have some limitations, and its value may be contingent on (a) the stage of the counseling relationship (more important in relationship-building stages), (b) the kind of client problem (e.g., depression), (c) the ability of the clinician to be empathic, (d) the cognitive complexity of the clinician, and (e) the ability of the client to recognize empathy (e.g., a person who is psychotic may not have this capacity).

Principles found in person-centered counseling seem important in the treatment of trauma (Murphy et al., 2019), and quantitative studies support the effectiveness of person-centered therapy for clients who have experienced trauma. For example, counselors using person-centered therapy saw a reduction of several co-occurring problems among adolescent girls with sexual abuse-related post-traumatic stress disorder, including internalizing symptoms and aggression (Zandberg et al., 2016). In addition, it has been effective in promoting impoverished and abused children and adolescents' resilience strategies (Freire et al., 2005).

In addition to addressing trauma symptoms, person-centered therapy is beneficial in addressing several other mental concerns. Here is a sample:

- reduction of conduct disorder symptoms in youth (Ronan et al., 2016),
- decreased externalizing behaviors (Post et al., 2019) and increased socioemotional and behavioral well-being (Perryman & Bowers, 2018) for youth engaged in child-centered play therapy,
- reduction in depression symptoms in adults (Delgadillo & Gonzales Salas Duhne, 2020; Zuroff et al., 2016),
- decreased social anxiety symptoms in children and adults (MacLeod & Elliott, 2014; Stephen et al., 2011),
- enhanced social functioning and quality of life following person-centered, arts-based intervention for patients with dementia (Shoesmith et al., 2021), and
- increased parental involvement and children's self-efficacy (Lv et al., 2018).

Person-centered counseling, especially when contrasted with psychoanalysis, used to be seen as a short-term approach to helping. However, in recent years, with the advent of some of the newer therapies, like cognitive-behavioral and the postmodern approaches, it is now considered a longer-term approach when compared to these briefer forms. Thus, in today's therapeutic climate, for problems that are focused and can be "fixed" within a short amount of time, person-centered counseling is generally not seen as the treatment of choice. However, for a wide range of other problems, person-centered counseling seems particularly suited and as effective as psychodynamic and cognitive-behavioral approaches (Elliott et al., 2018; Jacobs & Reupert, 2014; Sa'ad et al., 2014). For issues such as depression, embedded anxiety disorders, relationship concerns, and self-esteem issues, person-centered counseling is often the treatment of choice.

The Millers

The following shows Angela going through person-centered therapy. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Angela's Experience With a Person-Centered Counselor

Sitting in the somewhat cramped waiting room surrounded by glossy magazines, a cover featuring a mother and daughter, cheek to cheek, wearing broad toothy smiles caught Angela's attention. Emotion swept over her, leaving her feeling as if she might burst into tears before she even had a chance to introduce herself to this new counselor. Her thoughts drifted to her last counselor, Dr. Davis, and she wished she could talk to her again, but she was taking a year-long sabbatical and had highly recommended Henry Denshaw. "I refer to him regularly, and I hear good things," Dr. Davis had said. Angela felt a bit relieved when Henry retrieved her from the waiting room and led her to his office.

Angela sat on the bright-red loveseat situated against tall built-in bookcases lined with volumes of books and family photos. She sat silently, taking in the room, while across from her, Henry settled comfortably in a chair that was beginning to show its wear. Henry's concerned expression seemed to mirror Angela's hurt and to invite the tears that were welling up behind Angela's eyes. After a moment, Angela was able to speak, "I just feel at such a loss for what to do."

"The feeling of being lost and hurt is written all over your face. It is pretty clear this is a difficult time for you right now," Henry offered.

Henry, a person-centered therapist, is most concerned with providing Angela the space and the time to describe what she is feeling. Refraining from offering direction or questioning her, Henry believes that given the chance, Angela, like all clients, will be able to voice her innermost concerns and feelings. Henry strongly believes that given the right conditions, people will naturally realize their authentic selves. He believes that to give Angela what she needs, he first must try to fully understand her and convey that understanding to Angela. Henry works to attune himself to what Angela is saying as well as the feelings that Angela can name and those that are just beyond her awareness. While Angela does not say much initially, her body language speaks volumes. Henry hopes that as Angela begins to open up, he will be able to convey his understanding and his unconditional positive regard, while remaining authentic and present with her.

Henry believes that Angela's confusion and sadness is a symptom of the conflict between her natural tendency toward actualizing who she is (her self) and her need for positive regard (satisfying a role for others to win their love and approval).

"Things have been a little rough for my daughter, Celia. She's seven years old now and has so much anxiety at school that she has been getting stomach aches a lot. At least once a week, the nurse calls for me to pick her up. The situation is really stressing my husband. He got so upset when she had an

accident at school—she wet herself when she was getting on the bus to go on a field trip. The final straw came when Jake asked me to homeschool Celia again—he's really been pushing this on and off for a year, and I thought he understood my position on it, but he's at it again. I'm pretty sure that wouldn't be good for her. She needs friends. Frankly, I spent a lot of time working through this conflict around staying home with Celia, and caring for others generally, when I was in therapy with Dr. Davis, so I thought I'd worked through it. But here it is again—that old feeling that I should be doing more."

"This is a familiar struggle for you," Henry offers.

"Well, yes. As I think about it, I feel exactly the same way I felt the summer when I was eight years old or so. We were visiting my grandparents in Nigeria. My parents had gone to the market, and my father had left me in charge of my sister Lillian—she was three—and Markus was out playing in the yard with the other children. I had been watching her all summer long; at least, it felt that way. My parents were so concerned about her because of her bad hip. She had a hard time getting around on her own until she was able to get the first of her surgeries. At first, I felt like a grownup taking care of Lillian, but after a while, of course, I really wanted to go out with my cousins. One afternoon, I asked my grandmother if I could leave Lillian in the house with her and go with my cousins and the other kids to the river to fish. My grandmother gave me a very stern look and reminded me about my responsibility to my sister. It was just a look, you know, but I felt so … ashamed."

"I think where I feel stuck now is that I do believe it is OK for me decide I don't want to homeschool Celia and to work if I want to—but not if going to school is detrimental to Celia. I'm stuck, between Jake's over-anxious voice, my resistance to it, my desire to keep working, and the image of my grandmother telling me to do the right thing—and not being sure what that right thing is, frankly. I could use some advice."

Leaning forward in his chair, Henry begins, "Angela, I know that you would very much like to know what I think you should do. But I believe that only you can know what is right for you and your family. Maybe I can help you discover that."

As Henry reflected on his session with Angela, he returned to the belief that if he consistently provides an environment of empathy, acceptance, and unconditional positive regard, Angela will feel safe to explore her predicament and discover what it is she believes is the best course for her and her family.

As the session continued, Angela began to explore how being a caretaker had been a condition of worth that she felt strongly while growing up, both while in Nigeria and in the United States. Angela seemed to feel her family's love and approval most when she was caretaking. Any time she didn't want to be the caretaker, she felt rejected and ashamed. Angela acknowledged that she felt some of the same conditions placed on her by Jake. "It seems like as long as I agree to go along with what Jake wants, Jake will love me. But when I am assertive with Jake, he criticizes me and questions my commitment to the family. I'm growing tired of that," Angela offered.

As their second session opened, Angela was able to be more open about her frustrations with Jake. "Right now, I am so angry with Jake I can barely think straight. I'm still on the fence about what is best for Celia—for her to stay home or go to public school—but it makes me furious that he is putting me in this position," Angela explained. "I hate to admit this, but sometimes I get so frustrated with Jake and his anxiety. At first, I had a lot of sympathy for him—I really did. He's better than he was—I'll give him that—but his anxiety problem is really a problem for the whole family. I think at some level he expects me and the kids to change so that he doesn't have to feel anxious."

"So you are left feeling like an emotional yo-yo, going from sympathy, to anger, and then guilt, and, at times, just real confusion about how you should feel," Henry reflected.

"Yes, yes! That's right. It seems like I feel all these different feelings. But one thing I know—when Jake starts talking to me about homeschooling Celia, I get angry. Angry, because I feel like he doesn't at all value my job—my work! It isn't that I'm overjoyed about my job, but it is mine. But then when I really think about it, my work isn't all that important—not as important as Celia, anyway."

"You are really backed up against a wall. In order to get Jake's love and support you have to give up something that is meaningful to you and be responsive to his needs and feelings. Somewhere along the way, your own needs and feelings stopped being part of the equation," Henry offered. "I guess at this point, it is pretty difficult to figure out not only what you want to do for Celia but what you want for yourself."

"You know, Henry, I don't think I can remember a time when I've had a chance to really consider who I am outside of all these demands," Angela confessed. Henry hopes to help Angela feel supported and accepted as she explores her own needs and desires for the first time. He believes that, together, they can begin to make sense of her feelings of confusion, sadness, and guilt. As therapy continues, Henry is aware of how important it has been to provide her with the unconditional positive regard that would allow her to be free to explore her own struggles and to understand herself.

As Henry considers how their sessions might unfold, he expects he will be challenged to help her unearth a clearer vision of who she is. Henry's aim is to support the development of a self-image that incorporates both her American and Nigerian cultures to help her build greater confidence in her ability to make important decisions for herself and for her family and to help her decide what career and family roles make sense for her.

For You to Consider

1. Sometimes, when we work with a client like Angela who is torn and unsure about how to proceed, the answer may seem noticeably clear to us, but our answer may not be right for the client. Did you have a feeling about how Angela should respond to Jake's request that she homeschool Celia? If you were Angela's person-centered counselor, how would you help her to find her way to an answer to this dilemma?
2. If you had struggled with issues similar to those with which Angela is struggling, from a person-centered perspective, do you think it would ever be justified to share your similar struggles?
3. Take a look at each of Henry's responses. Do you think that they were empathic? Why, or why not? How might you have responded if you were Angela's person-centered counselor?
4. How difficult might it be for you not to ask questions of Angel, and, instead, to use empathy and other nondirective techniques to help her find her own solutions?
5. Do you think empathy is enough in Angela's case? Why, or why not?
6. Considering Jake's recent struggles, how effective do you think a person-centered approach would be for him, especially the use of the core conditions of genuineness, unconditional positive regard, and empathy?
7. If you were to use a person-centered approach with Jake, are there any ways in which you might adapt it for his unique situation?
8. How might you adapt a person-centered approach if you were working with Celia and Luke?
9. How long do you think Angela would need to spend in counseling to resolve some of her concerns? Is it feasible for her to be in counseling for an extended period of time?
10. How important do you think it is for you to learn about the Nigerian culture? From a person-centered perspective, do you think knowledge of that culture will help you relate more effectively with Angela?

11. If you found yourself having strong feelings, either negative or positive, toward Angela, as a person-centered therapist, what might you do with those feelings?
12. If you felt strong feelings about how Angela should act, would you share them? Under what circumstances might you share your feelings with her?

Summary

Growing up a shy boy outside of Chicago, Carl Rogers was to become the most influential therapist of the 20th century. Being raised with parents who were strictly religious, early in his career, Rogers hoped to become a minister. However, after deciding that the ministry was not his calling, he pursued graduate degrees in psychology. Although initially intrigued with the psychodynamic approach to counseling, Rogers eventually became disenchanted with the deterministic and reductionistic flavor of that approach and took on a more existential–humanistic orientation. As he refined his approach and began to develop his theory, its name changed from nondirective counseling to client-centered counseling to person-centered counseling. Eventually, Rogers developed a type of therapy that would revolutionize how counselors work.

The person-centered view of human nature has an existential flavor in that individuals are seen as freely making new choices throughout their lives. In addition, it takes on a phenomenological perspective, meaning that reality is seen as a function of each person's unique consciousness or understanding of the world. In addition, this approach believes that each person is born with an actualizing tendency that, if unimpeded, allows the person to reach their full potential. It also suggests that each individual has an organismic valuing process that assesses whether a person should move toward experiences or interactions that are positive to the actualizing process or away from those that are negative. However, person-centered counseling also believes that people have a need for positive regard, and when conditions of worth are placed on a person by significant others, this need to be regarded can outweigh the valuing process. This would result, said Rogers, in the person responding in nongenuine or incongruent ways as the individual attempts to act like they think others want them to act. How the person manages their organismic valuing process and the conditions of worth that are placed on the person is called the self. Person-centered counseling suggests that defense mechanisms that involve selectively perceiving situations, distorting situations, or denying threats to the self are created to prevent oneself from recognizing their incongruence and that anxiety, or other indications of personal struggles, are one sign that a person is living incongruently.

To help the reader understand person-centered counseling, a number of key concepts, many of which expanded on the person-centered view of human nature, were explained in this chapter. Thus, we took a more involved look at the actualizing tendency, the need for positive regard, conditions of worth, nongenuineness and incongruence, organismic valuing process, choice and free will, self-determination, nondirective counseling, and the necessary and sufficient conditions.

Although Rogers and other person-centered counselors do not like to use the word "techniques," they have identified a number of ways in which counselors tend to bring themselves into the helping relationship. These include exhibiting congruence or genuineness, unconditional positive regard, and empathy. It was noted that these three attributes are an important aspect of the six necessary and sufficient conditions of therapy. Although all three attributes were highlighted, the chapter took a more in-depth look at empathy, since it has been shown to be critical to positive client outcomes. It was noted that empathy is much more than reflecting feelings or parroting client statements and that the Carkhuff scale and other related instruments have been developed to systematically evaluate a person's ability to empathically respond. In addition, we spent some time examining advanced, creative, and novel approaches to empathy.

Relative to the therapeutic process, Rogers noted that as the counselor exhibits the necessary and sufficient conditions of therapy, clients evolve and increasingly show an increase in certain personality traits. For instance, clients feel increasingly safe, slowly but consistently open up over time, increasingly share their deepest feelings, exhibit an increased amount of insight, change behaviors to more effective ones, expand self-understanding, and become more autonomous. It was also noted that, today, person-centered counseling can last from a few sessions to a year or more and that clients, not counselors, generally direct the amount of time they spend in counseling.

Relative to social, cultural, and spiritual issues, we noted that person-centered therapy can be well-suited to work with diverse clients to support culturally responsive practice. However, we also pointed out that it might not be as effective with clients from a culture that extols external references and eschews an internal locus of control, who need brief and focused therapy, who might not feel comfortable with the expression of feelings, and whose presenting problems do not lend themselves to a person-centered counseling approach. With this in mind, we offered several recommendations for using a social justice framework within person-centered therapy and suggested some times when person-centered counseling should probably not be used. We also noted that it might not be as effective when the counselor's cognitive complexity is not evolved and when the cultural competence of the counselor is lacking. Relative to religion and spirituality, we pointed out that the person-centered counseling approach is open any value and belief that can be heard within the context of the therapeutic relationship.

As the chapter concluded, we pointed out that Rogers was one of the first to conduct research on therapy outcomes with his Q-sort technique, which looked at the difference between clients' self-concept and ideal self-concept, among other things. Available research indicates evidence of the core conditions for fostering client growth. In addition, person-centered therapy has been demonstrated as effective for addressing trauma, depression, anxiety, and other mental health and psychosocial conditions. It was also noted that empathy, so critical in person-centered counseling, has been shown to be particularly important to building a therapeutic alliance and to positive client outcomes. We pointed out that although empathy is critical to effective outcomes, not all counselors are good at it, some client problems are not well handled by it, and some clients cannot readily recognize empathy. We went on to note that although person-centered counseling used to be viewed as a shorter-term therapy, these days, with very brief approaches becoming popular, it is now considered longer term.

Key Words and Terms

actualizing tendency
additive empathy
advanced, creative, and novel approaches to empathic responding
antideterministic
Carkhuff Accurate Empathy Scale
choices
client-centered counseling
conditions of worth
congruence
core conditions
discursive responses
empathy
encounter group movement
existential
existential–humanistic
external locus of control
formula response
free will
full potential
genuineness
ideal self-concept
incongruence
internal locus of control
making a tactile response
microcounseling skills training
natural response
necessary and sufficient conditions
need for positive regard
nondirective approach to counseling
nondirective counseling
nongenuineness
organismic valuing process
person-centered counseling
phenomenological perspective
positive regard
process of defense
reflection of feelings
reflecting deeper feelings
reflecting media

reflecting nonverbal behaviors
self
self-concept
self-determination
subceive
subtractive empathy
unconditional positive regard
using a metaphor
using an analogy
using targeted self-disclosure

Key Names

Dewey, John
Gordon, Thomas
Kierkegaard, Søren
Rank, Otto
Rogers, Carl
Rogers, David
Rogers, Helen Elliott
Rogers, Natalie
Rousseau, Jean-Jacques
Skinner, B. F.

CREDITS

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SECTION III

COGNITIVE-BEHAVIORAL APPROACHES

The three approaches that constitute this area became popular during the latter part of the twentieth century and continue to have widespread appeal today. They include rational emotive behavior therapy, cognitive behavior therapy, and reality therapy. Cognitive-behavioral approaches look at how cognitions and/or behaviors affect personality development, behaviors, emotional states, and physiological responses. All of these approaches suggest that cognitions and/or behaviors have been learned and can be relearned. They tend to spend a limited amount of time examining the past, as they focus more on how present cognitions and behaviors affect the individual's feelings, thoughts, actions, and physiological responses. They all propose that after identifying problematic behaviors and/or cognitions, one can choose, replace, or reinforce new cognitions and behaviors that result in more effective functioning. These approaches tend to be shorter term than the psychodynamic or existential–humanistic approaches.

Accompanying this text is a video file that provides a role-play for each therapeutic approach being presented in Chapters 2 through 13. In addition, a separate video file that illustrates an integrative cognitive-behavioral approach with Jake Miller is provided with the book.

8 Rational Emotive Behavior Therapy

Learning Goals

At the conclusion of this chapter, readers will:

- be familiar with the life of Albert Ellis and the historical context in which he developed rational emotive behavior therapy (REBT)
- discuss how child-rearing practices, family dynamics, societal influences, and innate biology can result in rational or irrational thinking and understand how individuals have the potential to overcome irrational thinking
- understand the antideterministic, existential, learning-based, and, some say, constructivist view of human nature of REBT
- have a working knowledge of the key concepts of REBT, including: philosophical conditioning; unconditional acceptance; irrational and rational beliefs; cognitive distortions; the ABCs of feelings and behaviors; and using a rational, scientific approach
- examine several techniques of REBT, including demonstrating unconditional acceptance; teaching the REBT philosophy; being active and directive; challenging clients; demonstrating the ABCs of feeling and behaving; encouraging the disputing of dysfunctional cognitions, behaviors, and emotions; using humor; using metaphors and stories; and giving homework
- understand the five steps of the therapeutic process, including assessing the client's situation and hypothesizing how the ABCDEs apply, teaching the REBT philosophy, demonstrating how the client's situation fits the REBT model, directing the change process, and reinforcing change and terminating the relationship
- examine how the REBT approach can be used cross-culturally, especially in light of the use of the terms "rational" and "irrational" and the stress that is placed on tolerance by REBT therapists
- understand why this short-term, "rational" approach can be effective and what the future areas of research are for the approach

Sing the following to the tune of "Glory, Glory Hallelujah":

Mine eyes have seen the glory of relationships that glow

And then falter by the wayside as love passions come—and go!

I've heard of great romances where there is no slightest lull—

But I am skeptical!

Glory, glory hallelujah!

People love ya till they screw ya!

If you'd lessen how they do ya,

Then don't expect they won't

Glory, glory hallelujah!

People cheer ya-then pooh-pooh ya!

If you'd soften how they screw ya!

Then don't expect they won't.

Albert Ellis, "Song Lyrics: Glory, Glory Hallelujah!," *How to Stubbornly Refuse to Make Yourself Miserable About Anything: Yes, Anything*, p. 118. Copyright © 2006 by Citadel Press Books.

Hearing the satire in some of the songs by Albert Ellis makes the rational emotive behavioral therapy (REBT) approach truly unforgettable. As you might expect, REBT stands in stark contrast to the more psychodynamic approaches of Freud, Jung, and Adler, or the existential–humanistic approaches of Frankl, Perls, and Rogers. And although some have called Dr. Ellis a "foul-mouthed sexual revolutionary," others have anointed him as "one of the most influential psychologists of the twentieth century" (Spiegel, 2004, para. 2; Simon, 2007). Whatever you call him, there's little doubt that you will have a strong opinion of both Dr. Ellis and the theory he developed.

In this first chapter of cognitive-behavioral approaches, we present rational emotional behavior therapy (REBT), beginning with a biography of its founder—Albert Ellis. This chapter then presents his view of human nature; key concepts of REBT and its therapeutic process and techniques; social, cultural, and spiritual considerations; and REBT efficacy research. We conclude the chapter by illustrating REBT with Jake, a member of the Miller family.

Albert Ellis

Having passed away at the age of 93, Dr. *Albert Ellis* worked nonstop until the end of his life (Kaufman, 2007), and his last few years were as tumultuous as most of his life. For instance, when in his 90s, Ellis sued the board of the Albert Ellis Institute, which he founded over 50 years ago, for illegally removing him. The Supreme Court of New York State agreed and insisted that he be reinstated (Carey, 2006). His removal coincided with attempts by the board to restrict Ellis's access to Institute money and to prevent him from doing his weekly "REBT live therapy sessions" in front of upward of 200 people (Dobkin, 2005; Hafetz, 2005). After years of developing the Institute and taking a modest salary, Dr. Ellis believed the board was trying to usurp his authority—and, apparently, the courts agreed. But what is the history behind this great icon of cognitive therapy?

Born in Pittsburgh, Pennsylvania, on September 17, 1913, Albert Ellis was to become one of the most important theorists of all time (Neukrug & Ellis, 2015). The oldest of three children, Ellis moved with his family to New York City as a young child. Although Ellis states that his

FIGURE 8.1 Albert Ellis

parents "seemed to love [him]" (Ellis, 2004a, p. 49), he quickly adds that they were distant and aloof, his father often away on business trips and his mother narcissistic and opinionated. A sickly and frail boy, Ellis had numerous hospitalizations during his childhood. In fact, at one point when he was about seven years old, he was hospitalized with chronic nephritis for 10 months and remembers his father only visiting him once and his mother only once a week! However, even at this very young age, Ellis seemed to have a propensity toward handling difficult times in a logical and rational manner. In fact, perhaps, it was his parents' lack of attention that led him to become one of the greatest therapists of all time, as Ellis insinuates in an interview by Halasz, in 2004:

> I was anxious and somewhat depressed when my parents didn't show up regularly at the hospital, so I didn't want to be miserable. So I said to myself, what will I do not to be miserable and I figured out some of the rational techniques which I used later. My solutions were pretty good but not as good as the later REBT solutions. (Halasz, 2004, p. 326)

When Ellis was 12, he found out that his parents were divorced by overhearing a conversation between his aunt and mother (Ellis, 2004a; Halasz, 2004). Probably due to his lack of emotional involvement with his parents, he reports not being particularly affected by this. Ellis also notes that at around the same age, when studying for his bar mitzvah, he had a realization that God probably did not exist and that religion was not particularly important. He eventually became what he calls a "probabilistic atheist," which shows the importance he places on scientific evidence:

> [S]ince the probability of there being a God is 0.00001, I will assume there isn't any deity. If there is, and if he ever comes and talks to me, I'll ask him to prove that he really is God. (Halasz, 2004, p. 327)

You begin to get a sense of the foreshadowing of Ellis's methods when, at the relatively young age of 19, he decides to overcome his shyness of women by making himself talk to every woman who sat next to him on a particular bench at the Bronx Botanical Gardens, as he notes in a New York Times article by Hurley (2004):

> Thirty walked away immediately ... I talked with the other 100 for the first time in my life, no matter how anxious I was. Nobody vomited and ran away. Nobody called the cops. (Hurley, para. 21)

After earning a degree in business during the 1920s from the City University of New York, Ellis spent a few years in the business field and saw himself as a political and economic revolutionary (Halasz, 2004). However, after becoming disillusioned with this profession, he became a writer, often writing about human sexuality, which was a relatively new field. Ellis soon gained notoriety from this expertise and saw himself as a sexual revolutionary. Not surprisingly, before long, people began to come to him for advice about their sexual problems. Feeling like he had finally found an occupational fit, in 1942, he decided to pursue a master's and PhD in clinical psychology from Columbia University.

Due to Ellis's various phobias and neuroses, he became an avid reader of many different philosophies and "cured himself," using a variety of self-taught methods (Ellis, 2004b; Neukrug & Ellis, 2015). However, like many graduate students of his era, Ellis decided to embrace the theory of his

time and became trained in psychoanalysis. During this time, he also started a private practice. In 1943, he completed his PhD and was soon writing voraciously, authoring dozens of articles on a variety of subjects, from testing to sexuality to the importance of using scientific methods in research.

Although Ellis went on to obtain additional training in psychoanalysis, and also underwent his own analysis, he began to question the effectiveness of this approach. Soon, he was writing articles that questioned the scientific basis of psychoanalysis and began to shape a new approach that had at its core how neuroses could be explained as conditioned thoughts and behaviors and treated using directive techniques (cf. Ellis 1950, 1951a, 1956):

> My analyst used free association and really listening to his analysands. So I tried his method and ran up against all kinds of problems. I decided to give homework because I saw that people really didn't change unless they pushed their arse to do things differently. So I thought I would sneak in homework. But then I concluded in 1953 "this psychoanalysis is crap!" So I gave it up almost completely and went back to active-directive psychotherapy and started to develop REBT. (Halasz, 2004, p. 329)

In addition to his skepticism of psychoanalysis, Ellis began to question the importance of some of the "new" nondirective techniques, such as client-centered counseling, that were gaining in popularity (Ellis, 1948). The volume of this critique would increase throughout Ellis's life, as he became increasingly comfortable with his own approach.

In 1950, Ellis took a position as the chief psychologist of New Jersey, but by 1952, he decided to devote all his time to his private practice (Abrams & Abrams, 2012). Writing several books on human sexuality, Ellis became increasingly well-known, and his private practice began to flourish (see the following books by Ellis: *The Folklore of Sex*, 1951b; *The American Sexual Tragedy*, 1954; and *Sex Without Guilt*, 1958). In 1956, he founded and became the first president of the Society for the Scientific Study of Sex. A short time later, he became the American editor of the *International Journal of Sexology*. Perhaps ahead of his time, Ellis was found defending the publication of sexually explicit materials (modest by today's standards) and the lifestyles of gays and lesbians.

His advocacy for the publication of sexually explicit materials helped the American Nudist Association win a 1958 Supreme Court decision that condoned the sending of magazines with sexually explicit information (Neukrug & Ellis, 2015). However, the notoriety he gained resulted in his being denied speaking engagements and being banned from teaching positions at both his undergraduate and graduate schools.

In his young adulthood, Ellis was married twice and involved with many others (Ellis, 2004a). He saw these experiences as critical to his understanding of human sexuality and how to avoid being driven by the neediness that sometimes results when strong feelings toward another are not reciprocated. This discovery was critical to the development of his theory, as highlighted in his discussion around the ending of one of his marriages:

> For the rest of my life I have had very strong desires—many of them!—which I have striven to fulfill. But I have rarely thereafter thought that I absolutely needed what I wanted, nor strongly needed to avoid what I abhorred. And later I put antineediness, antiawfulizing, and antimusturbation solidly into REBT. (Ellis, 2004a, p. 94)

As Ellis continued to see clients in his private practice, he became convinced that it was how an individual came to view or understand their situation that caused disturbing, depressive, and upsetting emotions—not the situation itself. These beliefs, as Ellis himself said, were not new:

> [I]f you have right opinions, you will fare well; if they are false, you will fare ill. For to every man the cause of his acting is opinion. (Epictetus, 100/1900, p. 219)

During the 1950s, Ellis increasingly saw himself as a "rational therapist" and no longer associated himself with psychoanalysis (Ellis, 2015). His new directive and cognitive approach became known, in 1955, as *rational therapy*, and Ellis was soon seen as the first to practice *cognitive therapy*. His approach, which looked at how *self-defeating thoughts* and *irrational thinking* are the road to negative feelings and emotional pain, was initially ignored, criticized, or mocked by many prominent theorists:

> I was hated by practically all psychologists and psychiatrists. ... They thought it was superficial and stupid. They resented that I said therapy doesn't have to take years. (Hurley, 2004, para. 30)

Despite the animosity toward him and his approach, Ellis stubbornly continued on, and in 1957, he published his first book that highlighted his methods: *How to Live With a Neurotic* (Ellis, 1957). Two years later, he founded the Institute for Rational Living in New York City. Calling himself an experimentalist, Ellis continually modified his approach to fit the knowledge he gained by applying his techniques to himself and with the hundreds of clients he saw. He also periodically collaborated with *Aaron Beck*, who was independently developing his own form of cognitive therapy (Padesky & Beck, 2003). Although called a *cognitive therapist*, Ellis always said that thinking, feelings, and behaviors go hand in hand, and over the years, his approach began to incorporate more behavioral and feeling techniques. That is why Ellis eventually changed the name of his approach from rational therapy to *rational emotive therapy* and, finally, to *rational emotive behavior therapy* (Ellis, 2015). The Institute would have parallel name changes until in recent years, when it became known as the Albert Ellis Institute.

From 1965 to 2002, Ellis lived with *Janet Wolfe* in an open relationship (Ellis, 2004a). She was 24, and he was 51 when they met. The first office manager at the relatively new Institute, Janet would eventually obtain her PhD in Clinical Psychology and become the executive director of the Institute. In 2002, she decided to leave the relationship, which Ellis described as somewhat shocking and sad, while also noting that he could cope effectively with her decision through his REBT philosophy (Ellis, 2004a). In 2004, Ellis married *Debbie Joffe*, an REBT-trained clinician, who had been his assistant.

An innovative and prolific writer, over his lifetime, Ellis published over 1,500 articles, 85 books and monographs, and over 200 audio and video cassettes (Halasz, 2004; Neukrug & Ellis, 2015). Listed as one of the most influential therapists of all time, Ellis was the recipient of the American Counseling Association's (ACA's) Living Legend Award, the American Psychological Association's (APA's) Distinguished Professional Contribution Award, and, posthumously, APA's Outstanding Lifetime Contributions to Psychology Award (Neukrug & Ellis, 2015). There is little question that his theory greatly shaped the field of cognitive therapy as well as the broader field of psychotherapy. And although his scholarly writings will continue to affect the fields of counseling and psychotherapy, he will probably always be known for the quirky and interesting things he said over his lifetime, such as the following in an interview by Dobkin (2005):

> People are born crazy—all of them! ... As the Buddha said 2,500 years ago, they're out of their fucking minds. (p. 3, para. 8)

View of Human Nature

Believing we are *fallible human beings* who have the potential for rational or irrational thinking is the basis for REBT's view of human nature. *Rational thinking*, say REBT therapists, leads to healthy ways of living and results in people who show *unconditional acceptance* of self, others, and of the way things are. *Self-acceptance*, says Ellis, is different from self-esteem, which Ellis sees as an unstable process related to how others see us, as Ellis notes in an article by Davies (2005):

> Self-esteem is one of the worst evils known to man," Ellis is fond of saying, "because self-esteem means 'When I do well and you love me, then I am a good person; but when I do poorly and you don't like me, back to shithood go I.'" (para. 7)

In contrast to rational thinking, *irrational thinking* leads to emotional distress, dysfunctional behaviors, and neurotic ways of living as well as people who tend to be critical of others and of themselves. Although early child-rearing practices, family dynamics, societal influences, and innate biology tend to be the basis for the development of rational or irrational thinking, REBT therapists believe it is the individual who sustains their unique way of thinking (DiGiuseppe et al., 2014; Ellis, 2015).

REBT therapists believe there is a complex interaction between one's thinking, feeling, and behavioral states but that one's way of thinking is mostly responsible for self-defeating emotions and dysfunctional behaviors (DiGiuseppe et al., 2014). For instance, strong emotions, such as grief after the loss of a dear friend or sadness if one's house is flooded from a hurricane, would be considered a reasonable response, whereas a deep depression after the ending of a relationship or road rage at a fellow driver would be seen as unreasonable responses and a reaction to an irrational belief system. As you might expect, the depth and length of time for which one experiences a self-defeating emotion is related to one's beliefs about an event with extremely negative, self-defeating emotions being related to strongly embedded irrational beliefs.

BOX 8.1 Want to Meet Albert Ellis?

Want to hear a brief biography about Ellis from the man himself and find other tidbits of information about him? Go to https://silver.odu.edu/psyadm/ to see a caricature of Ellis talking about himself and his theory. Click on the cognitive-behavioral door, and go into Ellis's office.

Although REBT therapists view an individual's belief system as generally being created early in life, they believe that irrational beliefs that fuel maladaptive ways of living can be changed at any point. Long-winded examination of the past is not necessary and, indeed, says Ellis, could be harmful and inhibit progress toward change. For example, when interviewed by Aviv (2005), look at how Ellis talks about the importance of talking about the past:

> Freud was full of horseshit. He invented people's problems and what to do about them. Tell me one thing about the past. I'll prove it's not what upset you. It's how you philosophized about it that made you disturbed. (para. 2)

As you can see from the above quote, the insight-oriented approach of REBT has a strong *anti-deterministic* philosophy that asserts we can choose new ways of thinking and ultimately feel better and act in healthier ways (Ellis, 2015). Although generally placed in the *cognitive-behavioral school* of therapies, REBT can best be seen as a mixture of *learning theory* and *existential–humanistic philosophy*—learning theory in the sense that we learned a way of thinking, feeling, and acting that is self-perpetuating and existential–humanistic because we can choose to learn new and healthier ways of thinking, feeling, and behaving.

Ellis also argued that REBT is a *constructivist approach* because one can reconstruct one's meaning-making system by applying the theory (DiGiuseppe et al., 2014; Ellis, 1996a, 1998). However, because the constructivist school minimizes the notion of an external reality, and because REBT suggests there are specific rational beliefs that should be taught to the client by the therapist, some in the constructivist school have challenged Ellis's assertion (see Box 8.1).

Summarizing the above view of human nature, DiGiuseppe et al. (2014) suggest seven basic REBT principles:

1. Cognitions, not events, are the most important determinant of human emotion.
2. Irrational thinking leads to emotional distress.

3. Distress is best dealt with by addressing irrational thinking.
4. Genetic and environmental factors are antecedents to irrational or rational thinking.
5. Strong emotions are a sign that a problem needs to be addressed.
6. Therapy should focus upon the continued and ongoing self-indoctrination of irrational thinking, not historical influences.
7. Although beliefs can be changed, changing one's beliefs takes work.

Key Concepts

Some of the key concepts that are the underpinnings of rational emotive behavior therapy include philosophical conditioning, unconditional acceptance, cognitive distortions, irrational and rational beliefs, ABCDEs of feelings and behaviors, and using a rational, scientific approach of REBT.

Philosophical Conditioning

REBT therapists believe that the individual develops a way of understanding the world through their adherence to a unique philosophy (e.g., values, beliefs, and understandings) generally developed early in life (Velasquez, 2017). Each person's philosophy tends to become habitual, supports either rational or irrational beliefs, and is reinforced and sustained by the individual. One's *philosophical conditioning* can support irrational beliefs that lead to emotional distress and dysfunctional behaviors or rational beliefs that lead to healthy ways of living in the world. Philosophies are nondeterministic in that they can be scrutinized, analyzed, and changed at any point in a person's life.

Unconditional Acceptance

REBT asserts that healthy functioning comes through acceptance of self, acceptance of others, and acceptance of life—even when self, others, or life circumstances are not what one would like them to be (Ellis, 2015). Not accepting self, others, or difficult life circumstances dooms us to a life of despair and negative feelings; however, accepting that we are all fallible human beings, and that some things in life may be unfair or unjust, helps us move on and make better, more effective choices. Thus, it is critical that REBT therapists not berate clients for what they have done but encourage clients for what they can do. And perhaps more importantly, clients are encouraged and taught how to accept themselves and not rely on others for their self-esteem. Such acceptance helps to create an atmosphere where the client can develop a new, more rational belief system with associated behaviors and feelings that yield a more positive outlook on life. As you can probably guess, this *unconditional acceptance* is very different from the unconditional positive regard seen from the person-centered (Rogerian) perspective:

> I think nine out of ten people who go through Rogerian therapy conclude wrongly that "I'm okay because my therapist approves of me." But that's conditional love. I get people to truly accept themselves unconditionally, whether or not their therapist or anyone loves them. (Ellis, 2004a, p. 188)

Cognitive Distortions

Ellis and others have suggested that dualistic and inflexible thinking is related to the development of *cognitive distortions* (DiGiuseppe, 2014; Ellis & MacLaren, 2005). Such distortions are, in turn, responsible for irrational thinking, which makes one feel, as Ellis might say, "crappy" (see Figure 8.2).

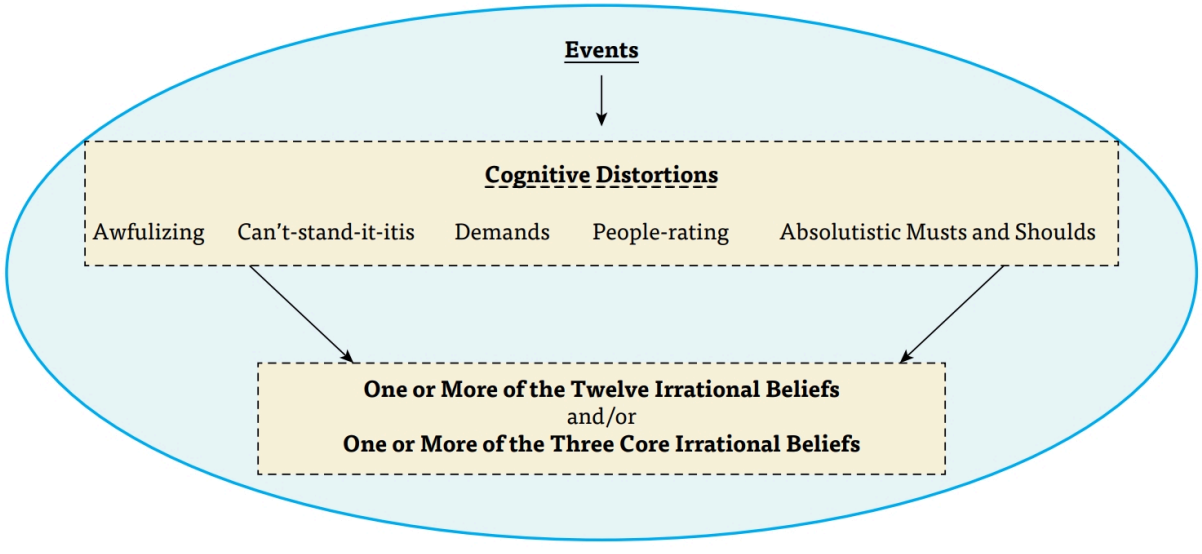

FIGURE 8.2 Relationships Among Events, Cognitive Distortions, and Irrational Beliefs

Some cognitive distortions include *absolutistic musts and shoulds*, *awfulizing*, *I-can't-stand-it-itis*, *demands*, and *people ratings*. Each of the distortions is defined below and is followed by an example of how it might be responsible for the creation of a specific irrational belief. See if you can identify possible feelings and behaviors associated with each cognitive distortion and accompanying irrational belief.

- **absolutistic musts and shoulds:** believing that one must or should act a certain way
  - **irrational belief:** "I must be the best parent," or "You are my child and must always be polite."
  - **feelings:**
  - **behaviors:**
- **awfulizing:** exaggerating an event so that it seems horrible, terrible, awful, or catastrophic
  - **irrational belief:** "It's so horrible, I can't even tell you what happened—okay, my husband abused me—I can't go on!"
  - **feelings:**
  - **behaviors:**
- **I-can't-stand-it-itis:** worrying about an event to the point that it feels unbearable
  - **irrational belief:** "I just can't stand those immigrants coming into the country and taking jobs away from us."
  - **feelings:**
  - **behaviors:**
- **demands:** demanding that oneself, or another, act in a certain manner
  - **irrational belief:** "You better come home early from work tonight; otherwise, I'm going to leave you."
  - **feelings:**
  - **behaviors:**

- **people ratings (damning oneself and others):** viewing a person as if they have all or none of a quality (e.g., good, bad, or worthless)
  - **irrational belief:** "I loved that woman; she was perfect. Why did she do this to me?"
  - **feelings:**
  - **behaviors:**

Rational and Irrational Beliefs

> We say that nothing is awful, nothing. Rape, incest, terrorism, Hitler—it isn't awful. ... When something bad happens, you can easily upset yourself, but you always have a choice to feel sorry, regretful, frustrated, annoyed, and not depressed, anxious, and despairing. (Ellis, 2004 as cited in Spiegel, 2004, 3:47)

As already noted, it is not the event that causes us to feel poorly, it is how the event is filtered through our cognitive distortions, which, in turn, impacts the development of irrational beliefs. Originally, Ellis came up with 12 *irrational beliefs*, and their associated *rational beliefs*, that people tend to embrace (Ellis, 1962, 1989; Smith, 1989; see Table 8.1).

TABLE 8.1. Twelve Irrational Beliefs and Corresponding Rational Beliefs

Irrational Beliefs	Rational Beliefs
1. The idea that it is a dire necessity for adults to be loved by significant others for almost everything they do ...	... instead of concentrating on their own self-respect, on winning approval for practical purposes, and on loving rather than on being loved.
2. The idea that certain acts are awful or wicked and that people who perform such acts should be severely damned ...	... instead of the idea that certain acts are self-defeating or antisocial and that people who perform such acts are behaving stupidly, ignorantly, or neurotically and would be better helped to change. People's poor behaviors do not make them rotten individuals.
3. The idea that it is horrible when things are not the way we like them to be ...	... instead of the idea that it is too bad; that we would better try to change or control bad conditions, so they become more satisfactory; and, if that is not possible, we had better temporarily accept and gracefully lump their existence.
4. The idea that human misery is invariably externally caused and is forced on us by outside people and events ...	... instead of the idea that neurosis is largely caused by the view that we take of unfortunate conditions.
5. The idea that if something is or may be dangerous or fearsome we should be terribly upset and endlessly obsess about it ...	... instead of the idea that one would better frankly face it and render it nondangerous and, when that is not possible, accept the inevitable.
6. The idea that it is easier to avoid than to face life difficulties and self-responsibilities ...	... instead of the idea that the so-called easy way is usually much harder in the long run.
7. The idea that we absolutely need something other or stronger or greater than yourself on which to rely ...	... instead of the idea that it is better to take the risks of thinking and acting less dependently.

Irrational Beliefs	Rational Beliefs
8. The idea that we should be thoroughly competent, intelligent, and achieving in all possible respects ...	... instead of the idea that we would better do, rather than always need to do well and accept ourselves as quite imperfect creatures, who have general human limitations and specific fallibilities.
9. The idea that because something once strongly affected our life, it should indefinitely affect it ...	... instead of the idea that we can learn from our past experiences but not be overly attached to or prejudiced by them.
10. The idea that we must have certain and perfect control over things ...	... instead of the idea that the world is full of probability and chance and that we can still enjoy life despite this.
11. The idea that human happiness can be achieved by inertia and inaction ...	... instead of the idea that we tend to be happiest when we are vitally absorbed in creative pursuits or when we are devoting ourselves to people or projects outside ourselves.
12. The idea that we have virtually no control over our emotions and that we cannot help feeling disturbed about things ...	... instead of the idea that we have real control over our destructive emotions if we choose to work at changing the musturbatory hypotheses we often employ to create them.

Note. From *The essence of rational emotive behavior therapy,* by A. Ellis. Copyright 1994 by The Albert Ellis Institute. Reprinted with Permission

The following gives examples of two irrational beliefs, from Table 8.1, that could have been incorporated into the belief system of a student who feels very badly about exam results. In the first example, a feeling and possible behaviors that might result from the eighth irrational belief are identified. What feelings can you identify, and what behaviors might result if the same student had incorporated the third and fourth irrational beliefs in the second and third examples?

- **Example 1:**
  - **student:** "I can't believe I didn't do better on this test—I am such a loser. I better have a perfect score on the next one."
  - **irrational belief 8:** "The idea that we should be thoroughly competent, intelligent, and achieving in all possible respects."
  - **possible feelings:** depression
  - **possible behaviors:** crying, sleeping too much, and a lack of interest in activities
- **Example 2:**
  - **student:** "My professor is a flaming idiot and doesn't know what he's doing."
  - **irrational belief 4:** "The idea that human misery is invariably externally caused and is forced on us by outside people and events."
  - **possible feelings:**
  - **possible behaviors:**
- **Example 3:**
  - **student:** "I will never get anywhere in life due to this test—things are just a mess."
  - **irrational belief 3:** "The idea that it is horrible when things are not the way we like them to be."
  - **possible feelings:**
  - **possible behaviors:**

In more recent years, Ellis reduced his 12 irrational beliefs to what he has called three *core irrational beliefs*, sometimes called *core musturbatory or grandiose irrational beliefs* (Ellis, 2015). Debbie Joffee Ellis notes that it is from these three core irrational beliefs that "countless others stem" (p. 850):

1. I must always be approved of and liked or loved by everyone.
2. You should always treat me well and act the way I think you should.
3. Life should always be fair and just.

Although later in his life Ellis rarely referenced his 12 irrational beliefs, he often would highlight his three core beliefs. However, many therapists today continue to find the original 12 irrational beliefs helpful and use them in practice. Although counselors will generally focus on irrational beliefs with clients, at some point, it is often helpful to also identify one's cognitive distortions, as they are the root of the irrational beliefs. Can you identify cognitive distortions that might underlie examples 1, 2, and 3 above?

The ABCDEs of Feelings and Behaviors

The REBT therapist addresses the client's irrational beliefs by using what Ellis called the *ABCDEs of feelings and behaviors* (DiGiuseppe, 2014; Ellis & Harper, 1975). Here the counselor labels the *activating event (A)*, the *irrational belief (iB)* about the activating event, and the *consequential feeling or behavior (C)*. *Cognitive self-statements*, or beliefs that result in negative feelings, are always rooted in one or more of the 12 irrational beliefs from Table 8.1, or the three core beliefs, and are also driven by cognitive distortions. Once the irrational belief is identified, the REBT therapist will *dispute (D)* it to develop new *effective responses (E)*—see the next section for ways this can be achieved. The result is new *rational beliefs (rB)* that result in new consequences that are less stressful and healthier.

For the following two examples, look at the activating event, the statement the client says to self about the event (i.e., cognitive self-statement), and the irrational beliefs and/or three core beliefs that underlie the cognitive self-statement and drive the person's consequences (feelings and behaviors). Then, examine some possible consequences from these irrational beliefs or core beliefs. The individual's *cognitive distortions*, which are driving the client's irrational beliefs, are noted at the end of each example.

- **Example 1:**
  - **activating event (A):** My lover has left me.
  - **cognitive self-statement:** I can't believe she left me. I feel like I have a hole in my heart. My life is nothing without her.
  - **irrational belief (iB):** irrational beliefs 1, 3, and 4 and/or irrational core beliefs 1, 2, and 3
  - **possible consequences (C):**
  - **feelings consequence:** depression and hopelessness
  - **behavioral consequence:** isolation and suicide attempts
  - **cognitive distortions:** awfulizing and I can't-stand-it-itis
- **Example 2:**
  - **activating event (A):** My boss chose another person's project over mine.
  - **cognitive self-statement:** I am really horrible at this job. I'll never amount to anything. What's wrong with me? He doesn't know what he's doing.
  - **irrational belief (iB):** irrational beliefs 3 and 8 and/or irrational core beliefs 1 and 3
  - **possible consequences (C):**
  - **feelings consequence:** anxiety, depression, and fear of the future

- **behavioral consequence:** difficulty doing work, inability to communicate with boss, and avoiding boss
- **cognitive distortions:** awfulizing and people rating (see Box 8.2)

Using a Rational, Scientific Approach

Using the *Socratic dialogue* method to help clients rationally examine their philosophical precepts, REBT therapists help clients identify irrational beliefs and their accompanying cognitive distortions (Ellis & MacLaren, 2005). In this method, the therapist leads the discussion, asks questions, and attempts to have the client see how their thinking process is illogical and leads to emotional distress and dysfunctional behaviors. Through this *philosophical discourse*, clients are challenged to show *evidence* that their irrational beliefs are true. Because this is an impossibility (irrational beliefs are, by their very nature, false and, thus, disputable), clients have no recourse but to accept the irrationality of their self-statements.

Once a client has accepted the irrationality of their beliefs, they can begin to replace irrational beliefs with rational ones and begin to experiment with new ways behaving and feeling, so they can begin to live a healthier lifestyle. Eventually, clients can also begin to change their cognitive distortions, which are at the root of their irrational thinking.

BOX 8.2 Irrational Beliefs, Cognitive Distortions, and Consequences

Your instructor may want to discuss the above examples with you in class. Are there other irrational beliefs, irrational core beliefs, or cognitive distortions you believe could lead to other consequences? If yes, discuss these in class.

REBT Techniques

REBT is a *psychoeducational approach* to counseling, which means it teaches the individual more effective ways of living in the world and helps the individual learn about their psychological self. This approach relies on several techniques that enhance the client's learning about the self, particularly ways in which the client distorts their cognitions and the accompanying irrational ways of thinking, and challenges the person to take on a new, rational approach to living. Some of the major techniques in this process include demonstrating unconditional acceptance; teaching the REBT philosophy; being active and directive; challenging clients; demonstrating the ABCs of feeling and behaving; encouraging the disputing of dysfunctional cognitions, behaviors, and emotions; using humor; using metaphors and stories; and giving homework.

Demonstrating Unconditional Acceptance

> [P]eople who achieve USA (unconditional self-acceptance) ... will not only fully accept themselves with their failings and "sins" but also will accept sinful and failing in others. (Ellis, 2006, p. 22)

From the moment a client steps into the REBT therapist's office, they are seen as a fallible human being. This basic understanding allows the therapist to show *unconditional acceptance* toward the client and, at the same time, recognize the inevitability of the fact that, as fallible human beings, people will sometimes exhibit behaviors that are toxic for themselves and others. The acceptance of the individual by the therapist allows clients to freely discuss their thoughts, feelings, or behaviors.

Teaching the REBT Philosophy

Because it is a psychoeducational approach, therapists will offer a wide range of activities that will help clients learn about REBT philosophy, including talking to them about it, encouraging them to read books and printed materials that describe REBT, offering them audio and visual aids that speak to the philosophy, and giving them web addresses for sites that explain REBT. Some of the typical philosophical points that REBT therapists will teach clients about can be found in Box 8.3.

BOX 8.3 Teaching the REBT Philosophy

1. We are born fallible human beings and have the potential for rational or irrational thinking.
2. Although the past may have affected us, we are not bound by it.
3. Because we are fallible human beings, it is important to learn how to accept ourselves and others unconditionally and not berate ourselves or others for behaving in ways that cause emotional distress or dysfunctional behaviors.
4. The ABCs: The cognitive distortion of events, and not the event itself, is what causes irrational thinking, dysfunctional behaviors, and negative feelings.
5. Irrational thinking is the result of our cognitive distortion, such as absolutistic musts and shoulds, awfulizing, I-can't-stand-it-itis, demands, and people rating (damning oneself and others).
6. Most of us have adopted one or more of the 12 irrational beliefs or three core irrational beliefs that are a result of our cognitive distortions.
7. We can adopt a new, more rational belief system that results in having appropriate feelings and functional behaviors.
8. Adopting a rational belief system will take practice, but we can overcome our past conditioning.

Being Active and Directive

Although listening and the use of empathy are not critical tools for the REBT therapist (see Box 8.4), basic listening to understand the situation is, of course, always necessary. In addition, the REBT therapist will administer assessment techniques, question the client, and encourage the client to talk, as they gather information from the client to assess how the client distorts events and uses irrational thinking. In addition, the client might be directed to obtain materials that will increase their understanding of the REBT philosophy and is encouraged to practice specific interventions aimed at changing the way they think, act, and feel. Often, this occurs by actively disputing the client's current way of thinking and teaching the client how to dispute on their own.

BOX 8.4 "Don't Give Me That Empathy Shit"

You can listen to this story, as well as other stories about Albert Ellis, by clicking on the link to Albert Ellis at the Stories of the Great Therapists website at http://www.odu.edu/sgt.

I (Neukrug) was a few years out of my doctoral program and was considering doing advanced training in REBT. I decided to apply for a post-doctoral fellowship at the Albert Ellis Institute. Having been trained as a humanistic therapist, this was going to be a stretch for me. However, I believed that REBT had much to offer and that I could learn much from this experience. I was asked to come for an interview. After interviewing with some of the staff, I was told that I would next have the "obligatory interview" with Al. As you can imagine, I was nervous. I was taken to his office—there he is, an icon, sitting in his big easy chair. I said hello, and we quickly were into the role-play. I did what I thought I should do—listened and used empathy as I attempted to assess the situation prior to moving into the REBT approach. After a couple of minutes of empathy, Dr. Ellis looked at me and said, "Don't give me that empathy shit." I quickly changed—afterward, he said that I did a pretty good job. Well, I guess empathy really is not that important in REBT.

Challenging Clients

From an REBT perspective, *challenging clients* should not be confused with heavy-duty confrontation. Challenging occurs when therapists suggest to their clients that they examine their current way of understanding their thinking, feeling, and behavioral processes. Subsequently, if they believe change would be helpful, clients can choose to adopt more rational beliefs as well as healthier behaviors and feelings:

> You are not going to tell them what to feel, what to do or what to think. Rather, you are going to help them to understand what their options are about what to believe and what the likely emotional, behavioral and thinking consequences are of each of these belief options. Once they have understood this, your job is to help them to choose the belief option that best helps them to achieve their healthy emotional, behavioral, and thinking goals. (Dryden & Neenan, 2003, p. 4)

Demonstrating the ABCs of Feeling and Behaving

Early on in therapy, the REBT therapist will use the "ABCs" to demonstrate to clients how their irrational beliefs, not their situations, are causing emotional distress. For instance, look at the following situation to see how the REBT therapist applies the ABCs to the problem being presented:

> *Client:* I am having an ongoing problem with my mother. She turned 75, my father (her husband) recently died, and I would like her to live with me. She's insistent that she wants to live on her own. She's healthy, but she can't live on her own forever. However, she never listens to anything I say and refuses to move in with me. I know she is perfectly capable of making her own decisions, but if she lived with me, she would be much better off. I just think she is taking a risk with her life! If I don't do something soon, I know something bad will happen. What if she falls and can't get to a phone? I am waking up in the middle of the night, having panic attacks about this. I haven't had a good night's sleep in months. Can you get her to listen to me?

In the above case, the client is concerned about his mother. The rational response would be to have some reasonable amount of worry about his mother's situation and, if his mother so chooses, offer some options for their mother. However, in this case, the mother does not want to do what her child wants and she seems perfectly content with her situation. The REBT therapist formulates the possible ABCs of this client's dilemma and explains it to the client:

- **activating event (A):** The client's father recently died, and mom now lives alone.
- **irrational belief (iB):** This client is awfulizing the situation with his mother and placing demands on themself. The client believes that things must be the way they want them to be (irrational belief #3), that unhappiness is caused by conditions outside of their control (irrational belief #4), and that they had better worry about these things; otherwise, they might happen (irrational belief #5). (See Table 8.1.)
- **consequences (C):** The client is having panic attacks and sleeping poorly—all the result of the irrational beliefs, not the activating event.

Encouraging the Disputing of Dysfunctional Cognitions, Behaviors, and Emotions

As clients learn the REBT philosophy, they realize many of their cognitions, behaviors, and emotions have not been healthy. Thus, they are encouraged by the therapist to dispute the unhealthy ones and replace them with healthy ones. *Disputations* can occur cognitively, behaviorally, or emotionally.

Cognitive Disputation

As clients begin to realize that it is not the event causing the feeling or behaviors, but the belief about the event, they are called upon to *dispute the irrational beliefs (DIBS)* that have been driving their emotional distress and dysfunctional behaviors. *Cognitive disputations* involve helping clients challenge their existing irrational beliefs, and in this process, DiGiuseppe et al. (2014) suggest not using "why" questions and, instead, using questions that draw out the reasons for the person behaving the way they do. Here are some examples:

- What evidence do you have to support this belief?
- How is that true?
- Might there be another way to think about your situation?
- What do you really think is the worst that can happen?
- What might you get out of thinking this way?
- Has thinking this way been productive for you?
- What do you think is the best way to respond?

The result of using these disputing questions is that the client's irrational beliefs are challenged. Eventually, the counselor can suggest that the irrational beliefs be replaced with rational ones. In our example, look at how new, rational beliefs replace the former irrational ones:

- **activating event (A):** The client's father recently died, and mom now lives alone.
- **rational belief (rB):** There is no evidence that mom is doing poorly, and I can wait and see how she does. I cannot control her decisions and cannot excessively worry about something I cannot control.
- **consequences (C):** The client has concern but not excessive worry about mother's situation and offers help the mother wants it.

Behavioral Disputations

In addition to cognitive disputations, it is often beneficial to practice behavioral changes that coincide with the cognitive ones. Thus, clients are often encouraged to practice *behavioral disputations* that challenge the irrational beliefs that are responsible for the behaviors (DiGiuseppe et al., 2014). *Risk-taking behaviors* are one kind of *homework* assignment often given to clients that encourage new ways of acting. Using our earlier example, instead of trying to convince their mother to move in with them, the client might ask her what kind of help, if any, she would like, given her new situation. Or taking this technique to another level, why not have the client ask their mother if they can help her plan a cruise or assist her in meeting new people? Such behavioral disputations would be directly competing with the irrational fears the client has been evoking.

Performing a *shame-attacking exercise*, which involves the purposeful acting out of a situation that might normally cause embarrassment, is a behavioral technique that reinforces the fact that approval from others is not necessary for self-acceptance (DiGiuseppe et al., 2014). For instance, clients might be asked to walk down a street wearing outlandish clothes or go up to strangers and tell them how nice they look. With our fictitious case, the client might go to older person gathering and purposefully approach several women about his mother's age and ask them how they might feel if they were happy in their living situation and had an insistent son constantly asking them to live with them.

Emotive Disputations

One of the most used *emotive disputations* in REBT is called *rational emotive imagery* (Ellis, 2015). In this process, clients are asked to close their eyes and focus intensely on the situation that is causing them extreme emotional upset. When the client experiences the emotional upset, they signal the therapist, often by lifting a prearranged finger. The therapist then asks the client to change the self-defeating emotion to an appropriate emotion, usually assigned by the therapist. After the client accomplishes this, the therapist asks the client what they were able to do to change the feeling (Ellis, 1996b). Usually, the client responds by stating that they changed the way in which the situation was viewed.

Thus, in our previous example with the older mother, the client would first experience the extreme worry and panic of imagining their mother's refusal to listen to suggestions about moving and, perhaps, even imagining the mother falling and being taken to the hospital. Then, the therapist asks the client to experience a different emotion—perhaps, a feeling of calm or maybe even happiness. As the client experiences one of these feelings, the therapist asks what they are imagining. In this case, the client might respond by saying that they see their mother sitting in their apartment, contentedly reading the newspaper (which results in a calm feeling) or, alternatively, they might visualize their mother enjoying a cruise (which results in the client feeling happy). Ultimately, rational emotive imagery teaches a client that one can have control over one's thoughts and, ultimately, over one's emotions and behaviors.

Using Humor

> REBT assumes that people had better take things seriously, but not too seriously. (Ellis, 2004a, p. 95)

As one can see from the song at the very beginning of this chapter, Ellis loved to use *humor* in making his point. It is not unusual to be walking down the halls of an esteemed institution of higher education and hear a counseling theories class belting out one of Ellis's songs. Ellis also

liked to quote the 16th-century philosopher, Michel Montaigne, who said: "My life has been filled with terrible misfortunes—most of which never happened."

REBT therapists see the humor that sometimes exists when individuals take on an irrational belief system. Unfortunately, many clients seem to want to wallow in their misfortune. Thus, REBT therapists will sometimes use humor to help clients see the ridiculousness of their plight (Ellis, 2015). Take the client who is fearful of their mother's future. It's ironic, and almost funny, that the mother is perfectly satisfied in life, and it is the child with the pathology! Pointing out the humor of a situation can help clients see the pointlessness and irony it.

Using Metaphors and Stories

Although a somewhat less direct method, *metaphors and stories* will sometimes be used to illustrate and reinforce points that the REBT therapist is trying to make (DiGiuseppe et al., 2014). Thus, the client who is so concerned about their aging mother might be told something like, "You know, your mother reminds me of the Empire State Building. Even though the building is aging, and from another era, it still stands erect and strong in the middle of the city."

Giving Homework

REBT therapists will actively encourage their clients to practice many techniques at home (DiGiuseppe, 2014). For instance, it would be common for REBT therapists to ask clients to practice, on their own, any of the disputation techniques mentioned or any of a number of other techniques, such as behavioral conditioning, bibliotherapy aimed at reading materials to reinforce new ways of being, expression of feelings, assertiveness training, or role-playing new behaviors. All these *homework* techniques are tried with the intent of maintaining the new, more rational belief system. A simple homework assignment for the client from the previous example would be to have them monitor their mom-related anxiety and catch their irrational thoughts when they do feel anxious (e.g., awfulizing thoughts, such as "mom's going to fall down and hurt herself") and replace them with rational thoughts ("mom's fine and can make her own decisions"). One might also ask the client to ask their mother what she would like out of life and help her make plans to accomplish those goals.

The Counseling Process

The REBT therapeutic process involves a series of steps that includes *assessing the client's situation and hypothesizing how the ABCs apply, teaching the REBT philosophy, demonstrating how the client's situation fits the REBT model, directing the change process*, and *reinforcing change and terminating the relationship* (cf. DiGiuseppe et al., 2104; Ellis, 2015).

Step 1: Assess Client's Situation and Hypothesize How the ABCs Apply

A client comes to therapy feeling upset, and it is the job of the REBT therapist to listen and actively assess the client's situation, understand the client's upsetness, and come up with a hypothesis as to how the client's irrational beliefs and cognitive distortions result in distress. Assessment occurs in several ways, including the use of standardized tests, biographical data inventories, client self-report, and interviewing (Ellis & MacLaren, 2005). The assessment process, which is ongoing throughout therapy, allows the therapist to consider how the ABCs apply to the client's situation.

In this beginning phase of therapy, and ongoing throughout all the phases, the therapist shows acceptance toward the client, although the therapist is also constantly encouraging the client to examine their life and eventually take on a new philosophy of living.

Step 2: Teaching the REBT Philosophy

After the therapist formulates a hypothesis, they are ready to share it with the client. But first, the client must understand the broader philosophy of REBT. Therapists need to actively encourage clients to take on this philosophy if they are to make any substantive changes. Thus, REBT therapists use psychoeducational procedures to help clients learn the philosophy of REBT (see Box 8.3). To reinforce the understanding of the REBT philosophy, pamphlets, books, internet resources, and other aids that clients can look at in the office or study at home might be suggested.

Step 3: Demonstrating How the Client's Situation Fits the REBT Model

Once understanding and acceptance of the REBT philosophy occurs, clients are ready to hear how the therapist's hypothesis applies to the client's situation. This is generally done by having the therapist present their hypothesis in the ABC formulation, as noted earlier. To facilitate this process, a handout that addresses the 12 irrational beliefs (see Table 8.1), and/or three core irrational beliefs (p. 222–223) are sometimes distributed to clients.

Step 4: Directing the Change Process

Now that the client has taken on the REBT philosophy and sees how it specifically applies to their situation, it is time to actively work on making change. Change can occur on three levels—cognitive, feeling, and behavioral—and often occurs using disputations, as noted earlier (the "D" of the ABCDEs, for "disputing"). Change occurs when clients can dispute their irrational thoughts, their dysfunctional behaviors, and their emotional distress, which leads to more effective responses (the "E" of the ABCDEs, for "effective"). In this process, using many of the techniques we discussed, the therapist actively suggests ways in which the client can rid themself of irrational and dysfunctional thoughts, behaviors, and feelings and adopt new, more rational and functional ones.

Step 5: Reinforcing Change and Terminating the Relationship

As clients increasingly become comfortable with REBT philosophy, they can apply it to other aspects of their lives. Although practice on their initial presenting problem should continue, they also are now able to understand how the basic principles of REBT can be applied to other problems in their lives. As they continue to make progress at working on their own issues, they develop an increasingly stronger acceptance of self and are better able to accept others in their differences and fallibilities. Armed with the tools of change originating from the REBT philosophy, clients can terminate therapy and work on their own. Ultimately, the client will adopt a new style of relating to the world in which they replace irrational beliefs with rational beliefs and the concurrent behaviors and feelings that go along with such beliefs.

Social, Cultural, and Spiritual Issues

> REBT, like some other therapies, is largely a form of tolerance training. It encourages you to think, feel, and act the ways you want—but warns against rigidity and fanaticism. (Ellis, 2004c, p. 211)

Mistakenly, many students believe that REBT is promoting a certain set of values chiefly because Ellis suggested that some ways of living in the world are more likely to create frustration, emotional distress, self-hate, and hate of others. However, his focus wasn't on any specific values; instead, he suggested that, regardless of one's values, anytime a person has absolutist, black and white, and dualistic thinking, one creates intolerance—intolerance to ourselves and intolerance to others. REBT can be an effective and affirming approach for a range of mental health conditions resulting from complex environments, particularly as counselors work with culturally diverse clients on unconditional self-acceptance and shifting irrational beliefs, where possible.

As counselors work with culturally diverse clients, they should be particularly aware of the stressors that they may experience, such as victimization, harassment, discrimination, rejection, concealment of identity, and internalized oppression (Hays & Gray, 2022; Moody, 2019). Counselors should assess how these stressors might activate irrational beliefs, which, in turn, result in negative feelings and dysfunctional behaviors—sometimes called *minority stress* (Moody, 2019).

An integral component of minority stress is cultural and gender role beliefs individuals possess, which can dictate what or how a person "must" or "should" do, feel, and behave (O'Kelly & Gilson, 2019). It is critical that counselors acknowledge how these beliefs have been sustained in part by familial and cultural expectations and marginalizing experiences. Applied to counseling women, O'Kelly (2011) highlighted demanding beliefs women typically hold:

- I must have someone stronger on whom I can rely.
- I must satisfy the wishes of others, particularly the men in my life.
- I must not act in such a way that upsets others.
- I must have a husband/male partner.
- As a woman I should not try to have senior positions at work.
- I should do everything I can to make myself look attractive.
- I should be responsible for the care of my children at all times.
- I should not rock the boat or be pushy.
- I should act passively in front of men.
- I should care for myself only when everyone else is taken care of.
- My children should not have any problems, since it would be my fault if they did.
- It is my responsibility to keep the house clean and tidy, do the washing, and prepare the meals.
- I should not try to get better pay/work conditions.
- I should not put my desires or wishes first.
- Things should go well in my family.
- I must have a child to be fulfilled.

Although designed for heteronormative women, these items can be adapted to women who do not identify as heterosexual or can be used with men to modify their irrational beliefs about women in their lives. In addition, counselors can work with clients of other marginalized identities (e.g., race/ethnicity, ability status, and spirituality) to develop lists of demanding beliefs they hold and work accordingly to increase the flexibility of those beliefs.

Others (e.g., Johnson, 2019; Moody, 2019) have noted key REBT concepts that counselors can address in their work with clients of marginalized statuses:

- **A-iB-C-D-E connection:** Counselors can validate the role that discriminatory practices have had on the development or sustainment of irrational or maladaptive beliefs and minority stress. Such validation conveys empathy regarding how clients may have developed the iB-C connection. Through this validation, counselors can empower clients to learn that they are not responsible for a discriminatory environment (i.e., disputation; Moody, 2019). As counselors work with clients to successfully change aspects of their environment where they can alleviate some minority stress (e.g., seeking social support from others with marginalized identities), counselors continually help clients understand the connection between irrational beliefs and consequences.
- **rational versus irrational beliefs:** Counselors can help clients transform irrational beliefs to rational beliefs. For instance, irrational beliefs such as "parents must love their children unconditionally" or "I must be treated well by everyone" can be transformed into more flexible rational beliefs, such as "I can find love and affirmation from many sources, and I am not limited to receiving unconditional love from my parents," or "I have the ability to advocate for fair treatment and accept myself as I am no matter others' limited understanding of my experience." Self-acceptance and rational beliefs about their marginalized statuses can help clients engage with positive role models, seek and obtain social support, and seek out inclusive environments of mutual respect and freedom of expression.
- **consequential feelings or behaviors:** Counselors working with marginalized clients can help them distinguish between healthy and unhealthy behavioral and emotional consequences. For example, consider a gay client who does not come out to others to prevent rejection. This results in anxiety, as the client is constantly telling themselves that they need approval from others. By exploring the full functionality of their anxiety, however, counselors can elicit from the client that the anxiety also serves to prevent them from being socially engaged and receiving social support.
- **shame attacking exercises:** REBT's focus on homework and testing new behaviors can be a valuable resource when working with culturally diverse clients. For example, O'Kelly and Gilson (2019) noted that women can act out new desired behaviors outside of counseling that do not fit traditional gender norms. Counselors can then process their experiences within therapy to continue to flex belief systems and build affirming environments.

REBT can be a beneficial approach for addressing spiritual issues in counseling (Johnson, 2019). Interestingly, Ellis's own thinking on the role of religiosity and spirituality in client's lives and REBT shifted during his professional practice. In 1973, he proposed a universal rejection of religious doctrine and noted that "no supernatural 'force' in the universe ... gives a damn about [clients] or ever will" (p. 16), viewing devoutness as linked to psychological distress and pathology. However, since the 1980s, Ellis noted that some religious belief can be therapeutically beneficial, as clients from various religious and spiritual backgrounds hold belief-oriented systems that are compatible with REBT work (Johnson, 2001, 2019).

> Although I have, in the past, taken a negative attitude toward religion, and especially toward people who devoutly hold religious views, I now see that absolutistic religious views can sometimes lead to emotionally healthy behavior. ... [P]eople who view God as a warm, caring, lovable friend, and see their religious as supportive are more likely to have positive outcomes than those who take a negative view of God and their religion. (Ellis, 2000, p. 31)

Johnson (2019) offers several best practices for the use of REBT with religious clients. First, counselors are to examine their own belief systems about marginalized clients, and how their own irrational beliefs were developed, can change or have changed and what impact their cognitions

have on their work with these clients. Second, the REBT counselor, in conjunction with the client, can assess the extent to which a client's presenting concerns are influenced by their religious and spiritual beliefs as well as how those beliefs influence presenting concerns. Third, the counselor can process with the client how religious writings connect to their presenting concerns in positive or negative ways. Fourth, if therapeutically beneficial, the REBT counselor can encourage religious and spiritual practices (e.g., prayer; attendance at church, temple, synagogue, or mosque; Biblical study). Working alongside clients, counselors can help them develop and evaluate interventions that support an adaptive integration of client religious and spiritual values within their lives (e.g., advocacy, social support, homework, and psychoeducation).

In sum, REBT can be used to reduce psychological distress of marginalized clients through reappraisal of irrational beliefs, developing and maintaining adaptive coping strategies, and increasing social support and general relationship quality. Any client, however, who holds firmly to absolutist thinking and rigid values will have a difficult time with REBT. In fact, Ellis says, they are likely to fuel hatred toward the world. The bottom line is: Understand differences, don't be absolutist or dogmatic, and don't rigidly practice "shoulds" or "musts" toward yourself or others.

Efficacy of REBT

For more than 50 years, those integrating REBT into their clinical work have focused on evaluating its theoretical components as well as clinical outcomes—beginning with Ellis himself. Although there are methodological limitations of Ellis's and others' studies of REBT, evaluating REBT has an emerging research base that shows it is developing as an empirically supported treatment, particularly for depression, anxiety, and trauma-related disorders. As a brief therapeutic approach, it is also well-suited for today's managed health care system.

There is empirical support for core assumptions of REBT, particularly as they relate to the A-iB-C-D-E connection. In particular, David et al. (2017) found in a 50-year systematic review and meta-analysis of REBT research that belief systems have a medium to strong effect (i.e., clinically meaningful) and are closely tied to the emotional and behavioral responses, particularly when there is the presence of a salient and relevant activating event. In addition, REBT effectiveness in terms of positive cognitive, psychological, and behavioral outcomes tends to be stronger with longer treatments (David et al., 2019a). In addition, holding and developing rational beliefs have been demonstrated to support clients' resilience in navigating psychological distress and negative events (Hyland et al., 2014).

The efficacy of REBT has been tested with both adult and youth concerns and is potentially helpful with working with students in K–12 settings. School counseling research has provided evidence of the A-iB-C-D-E connection: For example, studies reflect that there is a significant negative relationship between irrational beliefs and student efficacy and resilience, which correlated with psychological symptoms, such as depression and anxiety (Noormohamadi et al., 2019; Warren, 2010; Warren & Dowden, 2012). In addition, REBT principles have been applied successfully to response to intervention (RTI) initiatives to promote students' academic, psychosocial, and career development (Warren & Robinson, 2015).

David et al. (2019b) highlight that additional research is needed on major REBT constructs, especially the theory of change proposed in the A-iB-C-D-E connection. In addition, Lynn et al. (2022) note that randomized control trials (RCTs) and other types of research designs should consider or control for three areas of clinical concern during and after REBT treatment: (a) client variables (e.g., medication compliance, type and severity of client issue, cultural and personality characteristics, and treatment history); (b) therapist effects (e.g., REBT allegiance, therapist cultural and personality characteristics, and clinical setting type); (c) and process variables (e.g., length of REBT treatment, intervention type, and timing of interventions).

The Millers

The following shows Jake going through rational emotive behavior therapy. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Jake Sees an REBT Therapist

Initially, when the flyer passed his desk, Jake had not given much thought to it; a workshop about dealing with anxiety seemed, well, a little hokey. Still, he had not been able to get himself to throw the flyer out, and ultimately, when the workshop began, he found himself sitting in the back of the conference room listening to the speaker, Paula Kim, explain rational emotive behavior therapy and its efficacy in reducing work-related stress. On the following Wednesday morning, Jake made an appointment with Dr. Kim.

Dr. Kim's office was decorated in beige and gray tones that reminded Jake of cool, wet river stones. Jake noticed the contrast between the aged feel of the hardwood floors and the modern look of the large whiteboard that spanned one wall of the office. "So, Jake, can you tell me what has brought you here today?" A cascade of ebony hair fell just above her shoulders and framed Dr. Kim's shining black eyes.

"Well, sure, um," Jake began cautiously. "I used to have a lot of trouble with panic attacks, but I haven't had one in months. Lately, though, when I'm at work, I sometimes get so anxious that I feel a wave of panic—not a panic attack, though." Aware of his initial awkwardness, he added, "Um, I was at your workshop last week, and I thought maybe you could help." Jake explained, "I'm starting to feel really stressed out by this new project at work. I was excited about it at first. It seemed to be going really well, but there is a new project manager, Nadia, and she's pushed up the timeline and introduced some aspects that are really not in my area of expertise, if you know what I mean. The way she talks to me with her pushing and demanding is giving me those same old panic feelings."

"Even though this project has some exciting aspects to it, working with your project manager is getting to be harder and harder to deal with, especially when she starts to push and make demands," Dr. Kim offered. "Even though you've had the panic attacks under control, the worry that you might have another one is so distracting that it adds to the stress you already feel at work. Can you flesh this out a bit more for me?"

In the opening of the first session, Dr. Kim began to gain some insight into Jake's beliefs about his work environment and some of the triggers and irrational beliefs that seemed to be leading to Jake's anxiety. She believed it was important to convey her understanding of Jake's situation and to demonstrate empathy. However, Dr. Kim believed that Jake, like others, struggled with emotions not so much because of the challenging people and situations that make up his day but because of his irrational thinking about people and work. Dr. Kim hoped to help Jake identify and challenge the counterproductive beliefs and replace them with new more rational ones.

"You're right, Dr. Kim. I am so worried that I'll have another panic attack. It would be—well, it would be humiliating if that happened at work. I just don't think that I could stand that," Jake said, eyes wide.

"I can see concern written all over your face. Help me understand better what is frightening you about the possibility of having a panic attack at work," Dr. Kim probed.

"It's a couple of things, really. I don't know if you have ever had a panic attack, but when it happens, you feel like you are going to die! For me, I feel like I'm having a heart attack—I can't breathe, and I just want to get the hell out of wherever I am and get to a hospital," Jake said, his volume climbing a bit.

"That sounds terrifying, Jake," Dr. Kim replied. "You said there were a couple of things. What else scares you about it?" she prompted.

"Yeah, the other thing is just that Nadia and the people at work would think I was some kind of nut job! I'd lose the little bit of credibility I have with her, and it would be a constant battle to get her to listen to anything I had to say," Jake replied, visibly upset. "I'm not sure how you can help me, Dr. Kim. It seems like my project manager is the one who needs to be here! If she'd get off my back, I'd be fine, and I could get my work done."

"Maybe it would be a good idea for us to go over some of what I talked about at the workshop and see if we can figure out together how this applies to your situation at work," Dr. Kim said as she walked over to the whiteboard and began to write. "You probably remember from the workshop that it isn't the specific events in our lives that pester us and cause us to suffer." Dr. Kim jotted down the words "A = Activating Event" as she continued, "It is the way that we think about those events that lead to how we feel and act." She then wrote "B = Belief about Event," and "C = Consequential Feeling or Behavior," and then connected the three with an arrow, illustrating their relationship. "Does that make sense so far?"

"I remember that part, but I'm still not sure how that fits with the situation at work," Jake confessed.

"Well, let's take a look." Dr. Kim began. "When something happens, Jake, like when Nadia starts to ride you at work, that is an activating event." Dr. Kim jotted her example on the whiteboard. "So, 'A,' in this case, is your project manager criticizing some aspect of your work. Here, 'B' is the belief you have about that event, and 'C' are your feelings—in this case, panic. Ultimately, it is your beliefs that you really can't handle your project manager's bad temperament and that, because you can't handle Nadia, you will inevitably have a panic attack that will lead everyone, without exception, to think you have lost your mind. It seems to me that your panic feelings are a response to all those concerning and distracting beliefs, rather than your project manager's tone of voice."

"Well, I guess, I can see where you are coming from," Jake conceded. "But to be honest, it really does feel pretty intolerable when this woman starts in on me—you should hear her!"

"Jake, I believe you. She sounds really difficult to deal with, but my focus is on you. Let's get your thoughts and reactions figured out so that you can deal with her—she's probably not going to change."

"I feel like you are unloading this whole situation on me. Like I'm some kind of ninny. I'm not sure I like where this is going," Jake replied.

"What just happened here, Jake?" Dr. Kim replied. "I wonder if what you were hearing from me sounded like I was blaming you, somewhat like what you hear from Nadia. Are you worried I think you are a ninny?"

Jake snapped, "Yes! Something like that."

"Well, Jake, I don't think you are a ninny. I'm sorry it felt that way. In the theory I use I make sense of reactions by understanding this ABC process. Just like in this moment, I believe the perception that I was criticizing you was an activating event for you. Perhaps some belief about what it would mean to be a ninny or of being thought of as one followed that criticism and led to the consequence of being hurt and angry."

Jake nodded, "Maybe so."

Dr. Kim continued, "If you are willing, I have some homework for you. In the coming week, I'd like you to note the self-critical and catastrophic thoughts that come to mind when Nadia is pressuring you. If you can, try writing some alternative thoughts that might be more productive. We'll talk about them the next time we meet."

Despite their misunderstanding, Dr. Kim was pleased with her first session with Jake. They had been able to uncover some of Jake's beliefs and fears that seemed to be feeding the anxiety he feels when he is working with his project manager. They had gone over the ABC theory and clarified connections between the theory and Jake's situation at work and also used it more immediately to deconstruct their misunderstanding. Jake agreed to document his thoughts and to make an effort to create alternative thoughts to challenge the counterproductive ways he talks to himself.

Jake entered Dr. Kim's office for his second session looking a bit tired, eyes red, and his sleeves rolled up to the elbow, collar open, and his tie askew. "This was not a good day," Jake said. "I had a hard time sleeping last night, thinking about a meeting we were having at work today and wondering what Nadia was going to think about the new timeline I've drawn up. I knew she was going to flip out on me and humiliate me in front of everyone at work. I kept imagining myself having a panic attack, an ambulance coming, and an EMT guy announcing it was all in my head. My heart was racing all night," Jake explained. "I was exhausted by the time I got to work."

"So what happened?" Dr. Kim prompted.

"Well, the meeting started off okay. Everyone presented their stuff. Of course, Nadia tore into the budget guy when his figures didn't match the initial projections, and she blasted the intern about the webpage. By the time I was supposed to go, I was feeling pretty nauseated, and I was sweating," Jake explained, wiping his brow.

"It sounds a little like lining up in front of the firing squad," Dr. Kim observed.

"Yeah, that sounds about right. I was starting to panic, so I excused myself. I felt like an ass, but I had to get myself together before I went back into the conference room. So I went into the bathroom and washed my face and took some deep breaths. After about 10 minutes, I went back in and showed my timeline. Then, I told Nadia I wasn't feeling well. She said we could talk later about the timeline, and she let us go," Jake replied.

"Sounds grisly," Dr. Kim said. "What happened after the meeting?"

"As I was getting my stuff together, I overheard a couple of people in the office next to mine saying how much they hated these meetings. The lady from advertising poked her head in my office and said she was sorry I was sick but really glad that Nadia had ended the meeting early. She volunteered to be sick next time," Jake said. "I guess I'm not alone—lots of people seem to feel the same way I do about her."

"You lost a lot of sleep worrying that you would have a panic attack and that your colleagues would think that you were crazy," Dr. Kim pointed out. "You were right that Nadia, true to form, was pretty critical of everyone's work, but you managed through it, and it sounds like your colleagues sympathized with everyone there."

"I was thinking about that on my way over here. I have been writing down some of the thoughts I've been having this week, like you asked, and I noticed that about half the time the thing I was afraid of never really happens, and the other half of the time, it wasn't nearly as bad as I thought it would be," Jake offered.

"What did you make of that, Jake?"

"Well, I was remembering what you were saying about beliefs causing emotional reactions, not the event. It seems like that is kinda true because I get myself all worked up to match my belief about what is going to happen, and it seems like it is way out of proportion to the actual event," Jake replied.

"Sounds like you are making some real sense of the ABC theory." Dr. Kim smiled. "I wonder if you remember the handout I gave at the workshop about the three core irrational beliefs? I've got a clean copy of it here for you," she said, handing a sheet to Jake. "Most irrational thoughts can be traced to one of these three ideas. I've adapted them to fit your situation."

1. "I absolutely must under all conditions be sure my projects are perfect and that I have absolute approval from my boss and everyone else, or else I am an inadequate and unlovable person!"
2. "My kids, Angela, my boss, and everyone I encounter absolutely must under all conditions treat me fairly and justly and recognize my expertise, or else they are rotten, damnable, and intolerable persons!"
3. "Conditions under which I live and work absolutely must always be the way I want them to be, give me almost immediate gratification, and not require me to work too hard to change or improve them, or else it is awful, I can't stand them, and it is impossible for me to be happy at all!"

After reading through the sheet, Jake laughed. "Those are a little exaggerated, but I guess I do think like this sometimes. It looks pretty silly on paper."

"Let's see if we can make some connections between the thoughts you wrote down this week and these three core ideas," Dr. Kim prompted.

Jake pulled his crumpled list from his pocket. "Well, the first one I had was, 'If this timeline isn't perfect, Nadia is going to freak out on me, and I will have a panic attack. Everyone will think I'm crazy, and I will be a laughingstock.' That one really bothers me."

"So what irrational beliefs do you hear in there?" Dr. Kim prompted. Jake paused a moment and then began, "I definitely see number one in there. I did feel like the project had to be perfect and that I needed everyone's approval. I didn't think about how if that didn't happen, I'm not a good person, but I do think that is at the core of this whole thing." Jake paused again and continued, "I think, if I'm really honest with myself, there is a little of number three in there, too. I hadn't really thought about it in such extreme terms, but I guess I am insisting that things at work have to be just the way I want them to be in order for me to be happy. I hope that isn't true because, like you said, Nadia probably isn't going to change."

"Jake, what do you think would be a more productive and maybe more rational way to think about the timeline and the meeting with Nadia and your coworkers—instead of what you've written down?" Dr. Kim asked.

"Hmmm—well—maybe, 'Nadia may not like this timeline, but it's the best projection I can make with the information we have. She might flip out, but that doesn't mean I have to.' I guess another more rational thought might be that 'people at work might think I'm crazy, but I can't control them or their thoughts,'" Jake replied.

"What feelings come up for you when you use the alternative thoughts?" Dr. Kim asked.

"I feel relief, to be honest, and a little foolish, too, for letting myself get too caught up in these ideas that are more like fantasies than fact," Jake confessed.

Looking over their session notes, Dr. Kim considered where they and Jake might take their next sessions. Dr. Kim began to draft homework assignments for the coming weeks. They hoped Jake would read more about REBT, so he might have a deeper understanding of the philosophy. They believed Jake would benefit from understanding that we are born fallible and are not perfect and that we are not bound by our past. They hoped that through reading and reflection, Jake may more fully accept himself as fallible and stop berating himself when mistakes are made. By becoming aware of their absolutist thinking, Jake would have the power to combat those thoughts and, ultimately, to affect the feelings that result from these beliefs.

Dr. Kim also hoped to teach Jake some basic coping skills for managing anxiety when it arises. She believed that, in addition to rational thoughts, Jake could make use of controlled breathing and imagery to help ward off an influx of panic. Dr. Kim hoped Jake would welcome her suggestion that he begin an exercise program, since regular exercise seemed to reduce his stress and anxiety. Another practical step that she would suggest to Jake would be to reduce the amount of caffeine he drinks—Dr. Kim had watched Jake drain a large coffee nearly every session since he began coming to the office.

During their last session together, Jake sat looking out of the large window in Dr. Kim's office, noticing how the season had changed since their first meeting. The yellow and red leaves that lay like a carpet on the narrow patch of lawn edging the sidewalk signaled the passage of time. "I guess I've made a lot of progress with these irrational thoughts. I noticed this morning that I hadn't felt any really strong anxiety in weeks," Jake offered, as if to no one in particular. Then, turning to Dr. Kim, "Nadia announced yesterday that she is leaving; she didn't say why, but she said that I should apply for her position. She said she thought I'd do a really good job."

"There is some sadness in your voice, Jake. What are you feeling?" Dr. Kim asked. "Well, I guess I'm kinda left feeling confused and, yeah, I guess, sad. I mean, for months I was just miserable, and to hear Nadia talk now, it seems like she likes the work I do. I don't get it. It seems like such

a waste. It makes me mad at her. I mean, why act that way if she didn't hate my work? But more importantly, why didn't I trust myself? I knew I was knocking myself out to do the best work I could do—so why did I do that to myself?"

"I think I understand how you feel. For several months there, you were absolutely miserable, and for what?" Dr. Kim replied. "You regret that you didn't use your own measuring stick to judge your work; you wish you'd trusted yourself and all the hard work you were putting into the project. And perhaps, you wish you had been using rational thinking to manage challenging projects and prickly people."

"I guess that about captures it. I can't do anything about what the people at work do or think, but I have got control of myself. I don't really have to feel like that again if I don't want to. I have you to thank for that, Dr. Kim," Jake offered with a shy smile.

"You did it, Jake—I just provided the ideas," Dr. Kim said, returning the smile.

For You to Consider

1. Dr. Kim believes the thoughts that are related to Jake's anxiety and negative feelings are irrational. Do you agree with her?
2. Jake has struggled with anxiety about his children and their safety. What irrational thoughts do you think might underlie these fears? Can you create a chart depicting Jake's anxiety at home using the ABC theory?
3. As with Jake, many of the irrational beliefs that we develop are born in early experiences. What experiences do you think helped to form Jake's irrational thoughts?
4. What irrational beliefs do you think Celia and Luke might be developing as they struggle with their own difficulties in school and at home?
5. Do you think REBT can be applied to children like Celia and Luke? What changes might you make in such an approach when working with children?
6. What cultural considerations might you encounter using an REBT approach with Angela, who identifies with two different cultures—Nigerian and American?
7. Do you believe there are some clients who would not be able to benefit from REBT? Why?
8. Relative to some of the other theories you have studied, how comfortable are you with the more directive and didactic approach taken in REBT?
9. Dr. Kim frames Jake's reactions to his program manager as based in irrational expectations that she would always treat him fairly and that she must appreciate his work. How might you think about Jake's reactions to Nadia using another theoretical perspective?
10. Some people struggle with the words "rational" and "irrational" in REBT. What are your thoughts on their usage?
11. Think about your developing counseling style and beliefs about human nature. What challenges might you experience if you were asked to use an REBT approach?
12. By examining the three core irrational beliefs, can you identify any of them as your own? In what situations might they affect your well-being?
13. If you identified any core irrational beliefs of your own, are there any self-management techniques you can develop to challenge those beliefs? Would you be willing to see an REBT therapist to work on challenging those beliefs?

Summary

Albert Ellis, the originator of what was initially called rational therapy, developed his approach to therapy during the 1940s after becoming disenchanted with the long-term intrapsychic approach of psychoanalysis. Finding he could help clients change by suggesting they examine the way they think about their situations, he began experimenting with different techniques and soon developed a relatively short-term, active, directive, and psychoeducational approach, which he called rational therapy. Eventually, he expanded his approach and renamed it rational emotive therapy, then rational emotive behavior therapy, to reflect the various dimensions he believed were important in the change process.

Although Ellis believed that early child-rearing practices, family dynamics, societal influences, and innate biology tend to be the basis for the development of rational or irrational thinking, his approach was unique in that he did not believe that spending time talking about the past was particularly important to the change process. Ellis saw people as fallible human beings, who have the potential for rational or irrational thinking, and believed that rational thinking leads to healthy ways of living and results in people who show unconditional acceptance of self, of others, and of the way things are.

Ellis highlighted several mechanisms that were responsible for what he called cognitive distortions of events in our lives. These included absolutistic musts and shoulds, awfulizing, I-can't-stand-it-itis, demands, and people-rating (damning oneself and others). These distortions, in turn, were responsible for the development of irrational thinking in clients. In working with clients, Ellis suggested that therapists focus on the ABCs of feelings and behaviors, with the "A" representing an activating event, the "C" representing the emotional and behavioral consequence of that event, and the "B" representing the belief about the event. Irrational thinking, as identified by the twelve irrational beliefs and later pared down to three core musturbatory or grandiose irrational beliefs, could be replaced by rational thinking, stated Ellis.

In this chapter, several key concepts central to REBT philosophy were identified, including philosophical conditioning; unconditional acceptance; irrational and rational beliefs; cognitive distortions; the ABCs of feelings and behaviors; and using a rational, scientific approach of REBT. To help people change quickly, a number of techniques were identified, including demonstrating unconditional acceptance; teaching the REBT philosophy; being active and directive; challenging clients; demonstrating the ABCs of feeling and behaving; encouraging the disputing of dysfunctional cognitions, behaviors, and emotions; using humor; using metaphors and stories; and giving homework.

It was noted that the REBT therapeutic process involves a series of steps that includes assessing the client's situation and hypothesizing how the ABCs apply, teaching the REBT philosophy, demonstrating how the client's situation fits the REBT model, directing the change process, and reinforcing change and terminating the relationship.

Relative to social, cultural, and spiritual issues, some have suggested that REBT promotes a certain set of values, particularly because it uses words such as "rational" and "irrational." However, others suggest that REBT is accepting of most value systems, unless one considers intolerance of self and others a value. Thus, the approach likely has use with a wide variety of clients with the exception of those who have strong absolutist tendencies or rigid, black and white ways of thinking. We went on to note how stressors can impact a culturally diverse client and that counselors should assess how stressors might activate irrational beliefs. We specifically addressed how minority stress impacts cultural and gender role beliefs and gave some examples of beliefs that some women might hold as a result. We also highlighted some ways counselors can specifically address their work with marginalized clients. Specific to religion, we noted that Ellis suggested that some religious doctrine speaks to the importance of tolerance toward others, and that this philosophy would go nicely with

an REBT approach. However, religions that tend to be dogmatic might cause problems for some clients who would be opposed to the tolerance suggested by this approach.

Studies on the efficacy on REBT go back to the 1950s, when it was found that "rational therapy" was particularly effective, especially when compared to some of the popular psychodynamic approaches. Since that time, a number of studies have shown that it is effective with a wide range of disorders, particularly depression, anxiety, and trauma. It seems to have stronger effects with longer-term treatment and has been shown to increase resilience of clients who embrace the REBT approach. Research also suggests it works well with both adults and students. Finally, it has been suggested that future research examine the impact of client variables; therapist style, personality, and setting; and process variables (e.g., length of REBT treatment, intervention type, and timing of interventions).

Key Words and Terms

ABCDEs of feelings and behaviors
absolutistic musts and shoulds
activating event (A)
antideterministic
assess client's situation and hypothesize how the ABCs apply
awfulizing
behavioral disputations
being active and directive
challenging clients
cognitive disputations
cognitive distortions
cognitive self-statements
cognitive therapist
cognitive therapy
cognitive-behavioral school
consequences
consequential feeling or behavior (C)
constructivist approach
core irrational beliefs
core musturbatory or grandiose irrational beliefs
demands
demonstrating how the client's situation fits the REBT model
demonstrating the ABCs of feeling and behaving
demonstrating unconditional acceptance
directing the change process
disputations
dispute (D)
dispute the irrational beliefs (DIBS)
effective responses (E)
emotive disputation
evidence
existential–humanistic philosophy
fallible human beings
homework
humor
I-can't-stand-it-itis
irrational beliefs (iB)
irrational thinking
learning theory
metaphors and stories
minority stress
people ratings
philosophical conditioning
philosophical discourse
psychoeducational approach
rational beliefs (rB)
rational emotive therapy
rational emotive behavior therapy
rational thinking
rational therapy
rational emotive imagery
reinforcing change and terminating the relationship
risk-taking behaviors
self-acceptance
self-defeating thoughts
shame-attacking exercise
Socratic dialogue
teaching the REBT philosophy
12 irrational beliefs
unconditional acceptance

Key Names

Beck, Aaron
Ellis, Albert
Joffe, Debbie
Wolfe, Janet

CREDIT

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9 Cognitive Behavior Therapy

Learning Goals

At the conclusion of the chapter, readers will:

- learn about the life of Aaron "Tim" Beck and the historical context in which he created cognitive behavior therapy (CBT)
- learn about the rational, active, educative, structured, time sensitive, empirical, antideterministic, and, some say, constructionist view of human nature of CBT and the relationship between genetic predispositions, biological factors, and experiences on the development of core beliefs
- learn key concepts of CBT, including the cognitive model (i.e., core beliefs, intermediate beliefs, and automatic thoughts and images), cognitive distortions, coping or compensatory strategies, and cognitive conceptualization
- identify 10 principles critical to effective treatment of CBT, and review essential techniques of CBT, including building a strong therapeutic alliance, educating the client about the cognitive model, Socratic questioning, identifying and challenging automatic thoughts and images, identifying and challenging cognitive distortions, identifying intermediate beliefs, identifying and challenging core beliefs, and doing homework assignments
- review commonly used techniques of CBT, including thought-stopping, imagery-changing, rational–emotional role-play, and behavioral and emotive techniques
- learn about the four stages of the therapeutic process: (a) intake and evaluation, (b) the first session, (c) the second and subsequent sessions, and (d) termination
- understand the components of culturally adaptive CBT for use with clients of diverse social, cultural, and spiritual backgrounds
- provide an overview of the many research studies that show the efficacy of CBT, but also examine how, despite the fact that CBT might be effective, it may be only as effective as other approaches to counseling and therapy

The thinking of the terrorist evidently shows the same kind of cognitive distortions observed in others who engage in violent acts, either solely as individuals or as members of a group. These include overgeneralization—that is, the supposed sins of the Enemy may spread to encompass the entire population. Also, they show dichotomous thinking—a people are either totally good or totally bad. Finally, they demonstrate tunnel vision—once

they are engaged in their holy mission (e.g., jihad), their thinking, and consequently their actions, focuses exclusively on the destruction of the target. They behave like robots programmed for demolition with no attention to the value of the human lives that are destroyed. In fact, like the Japanese Kamikaze pilots of World War II, they are gratified by the heroic role that destiny has accorded them. Bin Laden, himself, stated in an interview that he would be happy to die as a martyr. ...

We all have internal representations of ourselves and of other people. When we perceive ourselves or our group as threatened (often by a stigmatized minority), our internal representation of ourselves is usually of goodness and that of other people with whom we are in conflict with badness. Like the terrorists, we are disposed at these times to see ourselves as the victims victimized by the others, who are vulnerable and innocent. Over time our view of the other person or group progresses from *opponent* to *antagonist* to *Enemy*. We see the Enemy as dangerous, needing to be isolated, punished, or eliminated. We may seek revenge for the damage that we believe we have sustained or we may make a pre-emptive strike to forestall damage. The target of the violence is generally portrayed as the aggressor, as the victimizer. (Beck, 2002, pp. 211–212)

This powerful piece, by Aaron Beck, speaks to how all of us can perceive the world in distorted ways. Written prior to 9/11 in his book *Prisoners of Hate* (Beck, 1999), Beck knew that we *all* can develop distorted ways of viewing the world and that only through our ability "to generate rational thought and benevolent behavior" will we be able to develop "a more benevolent climate for the human race" (p. 248).

In this second chapter of cognitive-behavioral approaches, we present cognitive behavior therapy (CBT), an approach that can be used to help the individual understand and modify their *cognitions* to live a more meaningful, satisfying, and peaceful existence. We begin with a discussion of CBT's founder, Aaron Beck. We then present the view of human nature from a CBT perspective; key concepts, techniques, and therapeutic processes of CBT; social, cultural, and spiritual considerations; and CBT efficacy research. We conclude the chapter by illustrating CBT with Ann, a member of the Miller family.

Aaron Temkin Beck

The third son of Jewish immigrants, *Aaron Temkin Beck* was born in Providence, Rhode Island, on July 18, 1921 (Weishaar, 1993, 2015). His father, *Harry*, was in the printing business and known as a socialist, and his mother, *Lizzie*, was a women's suffragist who was described as having a strong and dominating personality. Harry and Lizzie had four sons and one daughter, with Beck being their youngest (Krapp, 2005). However, their first child, *Bernard*, died in infancy, and their second child, *Beatrice*, died as a young child in the 1919 influenza epidemic. It was said that Beck's mother never fully recovered from her daughter's death and wished that Beck had been a girl. At the age of seven, Beck broke his arm and eventually developed an acutely serious bone infection that required surgery. Beck remembers that, although he was not fully unconscious from the anesthesia, the surgeon started operating.

Beck remembers his father as "tranquil," while his mother appeared to be emotional, erratic, and overprotective (Krapp, 2005; Weishaar, 1993, 2015), and his emotion-filled relationship with his mother led him to be

FIGURE 9.1 Aaron Beck

particularly sensitive to others he perceived as having strong emotions. With his life-threatening illness, and his perceived overprotectiveness and emotionality from his mother, Beck developed several self-defeating beliefs, phobias, and anxieties early in life. For instance, Beck's absences from school due to his illness, along with memories of a very harsh teacher yelling at him, led him to believe that he was inept and incapable of achieving. Falling a year behind in school, Beck tried to convince himself that he could do better in school and, indeed, talked himself into overcoming his early negative beliefs about himself. In fact, he eventually ended up being one year ahead of his peers. Beck's ability to overcome his early, negative self-doubts is seen as the origin for his eventual theory that one's underlying *cognitive schema*, or floor plan, leads to beliefs about oneself and that one can challenge beliefs that lead to self-destructive behaviors.

Early in his life, Beck developed a fear of suffocation, no doubt related to his brother *Maurice*'s attempts at "playfully" trying to suffocate him with a pillow until he could no longer breathe. This fear led to a tunnel phobia, where Beck felt as if his chest was being constricted. Similar to how he overcame his feelings of being academically inept, Beck again decided he would confront his fear by actively seeking out tunnels to drive through and "talking himself through" the anxiety-producing situation.

Beck's mother and father both valued education and pushed their children to achieve (Weishaar, 1993, 2015). Graduating first in his high school class, Beck ended up going to *Brown University* and graduated with honors in English and political science. Despite a fear of blood and lacking the academic background to enter the medical field, in 1942 Beck applied and was accepted to *Yale School of Medicine*. Insistent on facing his fears, and with sweat from anxiety dripping off his forehead, Beck pushed himself to assist surgeons as he again forced himself into situations that would desensitize himself to his fears. Other phobias Beck overcame included fears of public speaking, heights, and abandonment, which he also attacked head-on by doing such things as forcing himself to speak in front of large groups of people and climbing up the Leaning Tower of Pisa.

Although Beck initially decided to go into neurology, when doing his residence at *Massachusetts General Hospital* during World War II, there was such a need for psychiatric residents that he suddenly found himself immersed in the field of psychiatry (Krapp, 2005). At the time, psychiatry was dominated by psychoanalysts, and when Beck suggested to his supervisors that he thought psychoanalysis was limited, he was told that it was his defenses talking. Thinking there might be some truth to this, he decided to embrace this approach he thought to be odd. Becoming increasingly involved in psychoanalysis, and even being supervised by the famous developmental psychologist and analyst *Erik Erikson*, Beck began to slowly embrace the psychoanalytic approach. Meanwhile, Beck had met *Phyllis Whitman*, and as the 1950s were ushered in, the two were married.

After finishing his residency at a psychoanalytically oriented hospital, Beck worked at the *Valley Forge Army Hospital*, just outside of Philadelphia. Here he counseled soldiers who were dealing with posttraumatic stress disorder from the Korean War. Although he dabbled in the use of other techniques, Beck continued to be mostly analytically oriented. In 1959, he joined the faculty at the *University of Pennsylvania* and soon started to research the effectiveness of the psychoanalytic approach (Krapp, 2005; Weishaar, 1993, 2015). However, discouraged with some of his findings, and as he increasingly saw clients, Beck began to slowly question the efficacy and usefulness of psychoanalysis. This skepticism increased after he found that many of his clients had streams of private thoughts that commented on their experience. Others, not aware of their private thoughts, quickly became conscious of them once Beck began to probe with them the possibility that such thoughts were present. Calling them *automatic thoughts*, Beck realized they "provided running commentary on the person's experience" (Weishaar, 1993, p. 20). Beck concluded that these thoughts were a function of an internal conversation with self and not associated with interpersonal dialogue. Thus, he came to believe that such thoughts, which seemed to affect how a person would think

and, ultimately, act and feel, would likely not be expressed in response to most analytic techniques, such as free association or dream analysis (Beck, 1991).

Beck's transition to CBT happened somewhat slowly. First, he began to give up some of the more traditional tenets of classical psychoanalysis, as he attached himself to some of the more radical analysts of the time, like *Alfred Adler* and *Karen Horney* (Padesky & Beck, 2003; Weishaar, 1993). However, as the years passed, his interest in cognitive work grew, and in the 1960s, he began to write about his new cognitive approach to psychotherapy. Finding analysts dismissing his ideas, he had little professional support but great encouragement from his family, especially his brothers and wife. In 1961, Beck published the *Beck Depression Scale* and started, increasingly, to write about the connection between depression and thinking. In 1963, *Albert Ellis* read some of Beck's publications, and realizing that the two of them were independently developing similar theories, began to correspond (Padesky & Beck, 2003). Although Beck and Ellis rarely wrote or researched together (Hyland & Boduszek, 2012), they did share ideas and met professionally at times. In fact, at one point, Beck consulted Ellis for continued anxiety he had around public speaking. Eventually, Beck called his theory *cognitive therapy*, although today, it is more frequently referred to as *cognitive behavior therapy*, or the more streamlined *CBT*.

Perhaps because Beck struggled with mild depression himself, he continued to study depression and how CBT could help with it. Obtaining grants to research his new approach, he soon was involved with a relatively large study that compared CBT with the use of antidepressants in treating moderately depressed clients. Out of this research came the book *Cognitive Therapy of Depression* (Beck et al., 1979), which was one of the first books to draw attention to CBT and advocated for a relatively short-term approach to counseling. Beck's writings and research were soon to usher in what some called the *cognitive revolution in psychology* of the 1970s (Weishaar, 1993, p. 27).

As Beck's theory evolved, he realized that different disorders presented with specific *cognitive distortions*, or false beliefs about the world, that fueled the disorder (Rice, 2015; Weishaar, 2015). Beck then developed training manuals that clinicians could use to help ameliorate the presenting problem by targeting the cognitive distortion(s) and behaviors associated with specific disorders. To assess clinical effectiveness of his training manuals, Beck developed several measures, including those that assessed depression, hopelessness, anxiety, self-concept, sociotropy–autonomy, and suicide. These tools allowed Beck to establish hundreds of studies that showed the effectiveness of CBT with a wide range of disorders. Most of this research was conducted at the University of Pennsylvania and, later, at the *Beck Institute for Cognitive Behavior Therapy in Philadelphia*, which he cofounded, with his daughter *Judith*, in 1994 (Beck Institute, 2021a).

Called Tim by his family and friends, Beck remained active in research and writing until his passing on November 1, 2021 (Beck Institute, 2021b; Carey, 2021). During his career, Beck published more than 600 articles and wrote 25 books. An unassuming man, over the years, Beck's research and writing brought him praise and dozens of award, including the prestigious *Lasker Award for Clinical Medical Research*, the *American Psychological Association's Lifetime Achievement Award*, the *Association for the Advancement of Behavior Therapy's Lifetime Achievement*, and the *American Psychiatric Association's Distinguished Service Award* (Weishaar, 2015). Listed as the second most influential psychotherapist of recent times (just behind Carl Rogers), Beck established his place in the annals of therapeutic history (Simon, 2007).

Beck, and his wife Phyllis, eventually had four children and eight grandchildren. Phyllis Beck was appointed the first female judge to the Superior Court of Pennsylvania and is often referred to by Beck as the person with whom he could bounce ideas off while developing his theory (Krapp, 2005). His daughter, Judith Beck, is now President of the Beck Institute and has written numerous books on CBT, including the well-received book *Cognitive Behavior Therapy: Basics and Beyond* (J. Beck, 2021; Beck Institute, n.d.). She and her daughter *Deborah Busis* have expertise in the use of CBT for weight loss and weight management (Beck & Busis, 2015) (see Box 9.1).

BOX 9.1 Want to Meet Aaron Beck?

Want to hear a brief biography about Beck from the man himself and find other tidbits of information about him? Go to https://silver.odu.edu/psyadm/ to see a caricature of Beck talking about himself and his theory. Click on the cognitive-behavioral door, and go into Beck's office.

Finally, a number of variations of CBT are often subsumed under the broader heading of cognitive-behavioral approaches. Some of the more well-known approaches include *rational emotive behavior therapy*, developed by *Albert Ellis* (see Chapter 8); *dialectical behavior therapy*, developed by *Marsha Linehan* (see Chapter 14); *acceptance and commitment therapy*, developed by *Steven Hayes* (see Chapter 15); *constructivist therapy*, developed by *Michael Mahoney*; and *multimodal therapy*, developed by *Arnold Lazarus*.

View of Human Nature

Beck suggests there is a *genetic and evolutionary predisposition toward emotional responses* that were adaptive in the distant past but can sometimes be maladaptive in today's world (e.g., anxiety and anger; Beck, 1967, 1976, 1999, 2005). Called the *continuity hypothesis*, these older, emotional responses are seen as "continuing" into the modern world (Scott & Freeman, 2010). Based on one's genetic predisposition, some individuals will tend to develop certain mental disorders when placed under stress. This Beck called the *diathesis–stress model of mental disorders*.

Although some individuals have a tendency toward exhibiting maladaptive emotional responses, a proportion of these will not express them if they were taught effective skills by parents and others, even if they had a genetic predisposition toward them. And taking a *rational*, *pragmatic*, and, some say, *constructionist* perspective. Beck assumes that even those who do exhibit maladaptive responses can change, in a relatively short amount of time, through therapeutic discourse with others, particularly if an individual learns how to modify their cognitive processes (J. Beck, 2005; O'Connor, 2015; Rice, 2015). Thus, CBT is seen as an *antideterministic*, *active*, *educative*, *structured*, *time sensitive*, and *empirical* approach to counseling that suggests that people can manage and effect changes in their way of living in the world if given the tools to understand their cognitive processes and how they affect feelings, behaviors, and physiological responses (Beck Institute, 2021c).

Beck and other cognitive therapists believe that a combination of genetics, biological factors, and experiences combine to produce specific *core beliefs*, some of which may lie dormant and then suddenly appear as the result of stress and other conditions impinging on the person. Core beliefs are embedded, underlying beliefs that provide direction toward the way one lives in the world (Beck, 1967, 1991; Scott & Freeman, 2010), with negative core beliefs leading to negative feelings and dysfunctional behaviors and positive core beliefs leading to healthy ways of living.

Beck suggests that most individuals are not aware of their core beliefs. Instead, such beliefs become the underlying mechanism for the creation of *intermediate beliefs*, which set the attitudes, rules and expectations, and assumptions by which we live. These attitudes, rules and expectations, and assumptions can be understood by looking at how situations lead to what are called *automatic thoughts* and associated *cognitive distortions*, which result in a set of behaviors, feelings, and physiological responses that end up reinforcing core beliefs. And thus, the cycle is continued.

Over the years, Beck and others have spent time showing how certain mental disorders are related to specific core beliefs, intermediate beliefs, and automatic thoughts (and associated cognitive distortions). Thus, if a counselor can accurately diagnose a client, that counselor can begin to make an educated guess as to some of the automatic thoughts and associated cognitive distortions, intermediate beliefs, and core beliefs the client might have.

Although CBT is mostly a *present-focused approach*, Judith Beck (2021) suggests that examining the past might be helpful when the client has a strong desire to do so and avoiding such

a discussion could harm the therapeutic alliance and when understanding of the past can illuminate why clients think the way they do and, thus, help them change their rigid thinking. In addition, today's cognitive therapists believe it is important to address all aspects of the individual if change is to occur relatively quickly. Thus, many who practice Beck's approach, or other similar cognitive approaches, will focus on cognitions *and* behaviors when working with clients. This has resulted in the more inclusive term, "cognitive behavior therapy," as opposed to the earlier term, cognitive therapy.

Key Concepts

Some key concepts that underlie CBT include the cognitive model (i.e., core beliefs, intermediate beliefs, and automatic thoughts and images), coping or compensatory strategies, and cognitive conceptualization.

The Cognitive Model

The *cognitive model* describes three levels of cognition: core beliefs, or the fundamental beliefs that underlie how we think, feel, and behave; intermediate beliefs, which consist of attitudes, rules and expectations, and assumptions that are outgrowths of our core beliefs; and automatic thoughts, which result in our behaviors, feelings, and physiological responses and are the outgrowth of our intermediate beliefs.

Although core beliefs are critical to the development of one's thinking processes, and ultimately to how one lives in the world, cognitive therapists believe it is usually important to initially focus on automatic thoughts, not core beliefs (see Figure 9.2). This is because core beliefs are seen as more embedded and less assessable than clients' automatic thoughts, and consequently, automatic thoughts are more easily "caught" and are a more natural starting point (e.g., a core belief of "I am inadequate" is much more difficult for a client to initially grasp than an automatic thought of "I never will get this report done right"). By assessing and diagnosing the client, and by examining the client's automatic thoughts, the therapist can begin to hypothesize about the intermediate beliefs that produce the automatic thoughts and, ultimately, begin to understand the core beliefs that fuel the intermediate beliefs. The following briefly describes core beliefs, intermediate beliefs, and automatic thoughts.

Core Beliefs

Beck originally distinguished between what he called *cognitive schemas* and *core beliefs* (Beck, 1967) and defined schemas as cognitive structures and core beliefs as the content that results from the structures. However, others, including Judith Beck (1995; Rice, 2015; Newman, 2016), suggest the differences are minimal and use them interchangeably. For simplicity, we will only use the term "core beliefs," which is broadly defined as those embedded beliefs that lend direction toward the way we interpret events and ultimately impact how we think, act, and feel. All of us have some positive core beliefs that lead toward positive ways of living (e.g., "I am an okay person," "I can control my life to a certain degree," or "I can achieve"), and many of us have some negative core beliefs that lead to dysfunctional ways of living (e.g., "I am not okay," "I am not capable," or "I am not likable"), which can result in lives that are debilitating, depressing, anger-evoking, anxiety-producing, and dysfunctional. Those who are particularly distressed are largely governed by their negative core beliefs, and many of us, when stressed, can be dominated by negative core beliefs for short periods of time. Aaron and Judith Beck (J. Beck, 2021) propose that negative core beliefs are of three broad categories: helplessness, unlovability, and worthlessness (see Box 9.2).

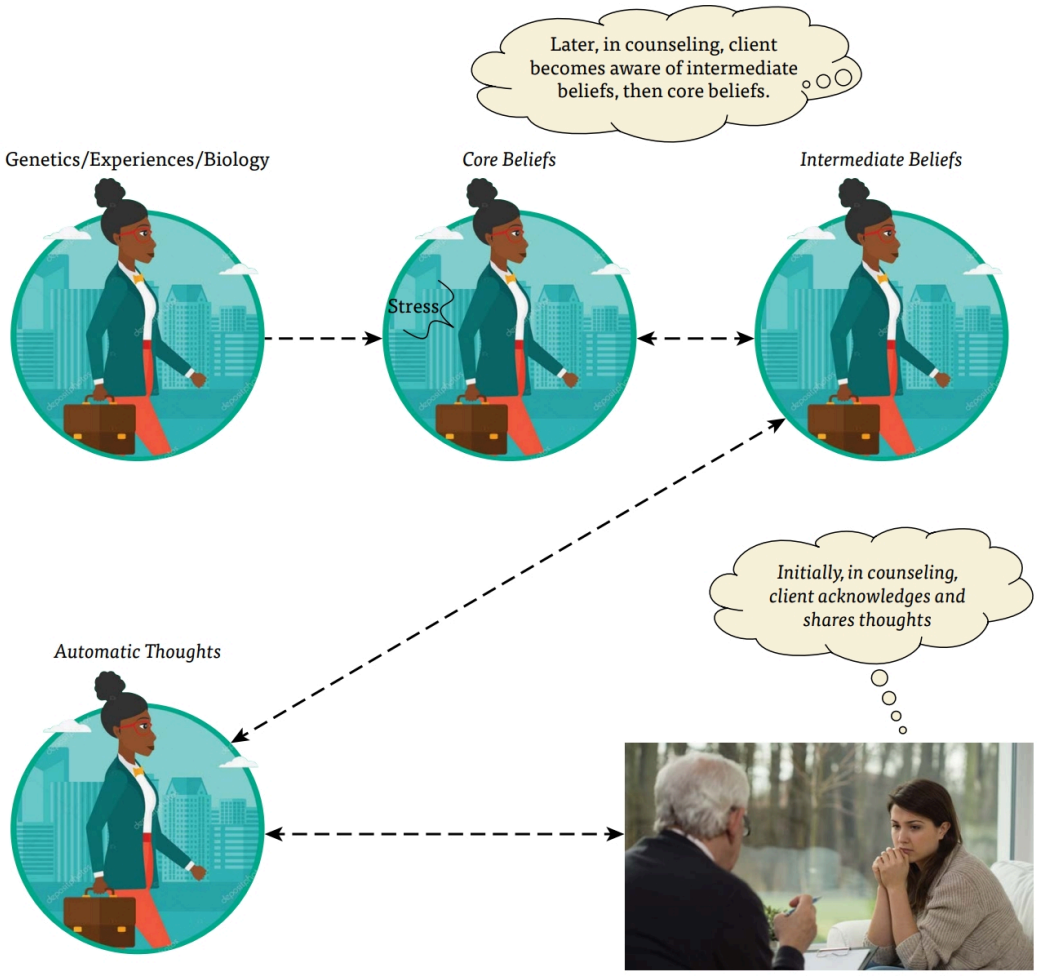

FIGURE 9.2 The Development of Core Beliefs, Intermediate Beliefs, and Automatic Thoughts

BOX 9.2 Negative Core Beliefs

When driven by one or more of the following three negative core beliefs, individuals tend to take on one or more of the following attributes associated with that core belief.

Helpless Core Beliefs
I am incompetent, ineffective, needy, trapped, out of control, a failure, defective, not good enough, a loser, helpless, powerless, weak, vulnerable, a victim, and/or I can't do anything right.

Unlovable Core Beliefs
I am unlovable, unlikable, undesirable, unattractive, unwanted, uncared for, different, bad so others won't love me, defective, not good enough to be loved by others, bound to be rejected, bound to be abandoned, and/or bound to be alone.

Worthless Core Beliefs
I am worthless, unacceptable, morally bad, immoral dangerous, toxic, evil, and/or I don't deserve to live.

Note. Adapted from *Cognitive therapy: Basics and beyond* (3rd ed.), by J. S. Beck, 2021, p. 33. Copyright 2021 by Guilford Press.

Intermediate Beliefs

Our core beliefs affect the kinds of attitudes, rules and expectations, and assumptions we have in life, which Beck calls our *intermediate beliefs*. Thus, if one of my major positive core beliefs is that I am capable of working out my problems, when I face challenges, my attitude will be something like, "I'm okay because I will make sure things will work out in the end." My rule and expectation might be, "Working hard resolves problems," and the assumption I live by is, "I assume things will work out if I work hard." On the other hand, consider the person who has the following negative core belief: "I am powerless to change my life." This person's attitude is something like, "Life sucks, and there's little I can do about it." Their rule and expectation is something like, "I expect that even if I try hard to change things, it will not work out, so why bother?" and the assumption is, "There is little I can do to make my lot in life better."

Automatic Thoughts

Automatic thoughts, which also includes images we may have, are those thoughts and images that cross our minds as we go through the day. When situations arise, individuals respond with *automatic thoughts* and *images* that are products of their attitudes, rules and expectations, and assumptions (intermediate beliefs), which, themselves, are developed from one's core beliefs. For instance, in the example just given, if the individual has a core belief that they are powerless to change their life, and that individual is suddenly faced with the breakup of a relationship, the situation (the breakup) will result in automatic thoughts based on the individual's intermediate beliefs which are, in turn, dictated by the individual's core belief of being powerless. Thus, this person might "automatically" say to themself: "Bad things always happen to me," "Life sucks," "Nothing ever works out," and "Even if I were to try, I'll find no one else." Automatic thoughts that are the result of negative core beliefs are closely associated with *cognitive distortions*, which are inaccurate statements or beliefs about the world that result in problematic behaviors and feelings. If you explore a person's automatic thoughts while they are in a period of distress, you will generally find that one or more of the cognitive distortions, listed in Box 9.3 are at play. Note the similarity of cognitive distortions here to the cognitive distortions identified by Ellis in Chapter 8.

BOX 9.3 Cognitive Distortions

- **all-or-nothing thinking:** Sometimes called *dualistic, black-and-white,* or *dichotomous* thinking, this occurs when individuals see the world in two categories, rather than in a more complex fashion.
  - **example:** "I am never good at my job," or "You are always happy."
- **catastrophizing:** making assumptions that something will go wrong, rather than looking at situations more realistically or scientifically
  - **example:** "I shouldn't have said that to my boss, I know I'll get fired," or "If I fly, the plane will crash."
- **disqualifying or discounting the positive:** even when a positive event occurs, assuming it means little in the total scheme of things
  - **example:** "That award I won at work is meaningless, everybody wins awards."

- **emotional reasoning:** assuming that your feelings are always correct, even when there is evidence to the contrary
  - **example:** "My wife and kids may tell me they love me, but I know I'm unlovable because I feel like no one can love me."
- **labeling:** defining oneself in terms of a "label" or "type," instead of seeing oneself in more complex and nuanced ways
  - **example:** "I'm just a negative person," or "I'm always introverted."
- **magnification/minimization:** magnifying the negative or minimizing the positive about oneself, another, or a situation
  - **example:** "I might have done well on that one test, but I know I'm not good in that subject," or "That incident at work proves that I am no good at what I do."
- **mental filter:** focusing on one negative aspect of oneself, another, or a situation
  - **example:** "I know why people stay away from me: They always see my disability."
- **mind-reading:** making assumptions about what other people are thinking without considering other possibilities
  - **example**: "She thinks I'm ugly. "
- **overgeneralization:** making large generalizations from a small event
  - **example:** "That dinner for my kids was horrible; I'll never be a good parent."
- **personalization:** believing you are the cause for other person's negative behavior without considering other possible explanations
  - **example:** "My colleague, James, was in a bad mood today because I didn't get that project to him in time."
- **"should" and "must" statements:** believing that oneself and others should act in a specific manner, and when they don't, believing it is horrible
  - **example:** "My grandmother was outrageous today; she never should have acted so boldly in front of the company."
- **tunnel vision:** only seeing the downside or negative aspect of a situation
  - **example:** "Her expressing her opinion is uncalled for. We'll never get friends that way."

Note. Adapted from *Cognitive therapy: Basics and beyond* (3rd ed.), by J. S. Beck, 2021, pp. 253–254. Copyright 2021 by Guilford Press.

Similar to automatic thoughts are the ongoing images we have that cross our minds throughout our day. For instance, a person who has difficulty finishing a project for work might be saying to themself, "I simply can't do this" or could have an image of their boss coming in with a disappointed look. Automatic thoughts and images result in behaviors, feelings, and physiological responses that reinforce core beliefs. Thus, a vicious cycle is developed.

Examining the Relationship Between Core Beliefs, Intermediate Beliefs, Automatic Thoughts, Cognitive Distortions, and Reactions

Figure 9.3 diagrams the relationship between core beliefs, intermediate beliefs, automatic thoughts and cognitive distortions, and how they affect and are affected by situations in a person's life. The arrows highlight how one's emotional, behavioral, and physiological responses reinforce the original core belief.

As an example, imagine the individual who has the core belief "I am powerless." When a situation occurs, automatic thoughts or images related to one's intermediate beliefs, which, in turn, are a product of one's core beliefs, kick in (see Figure 9.4). After looking at the automatic thoughts listed in Figure 9.4, refer back to Box 9.3, and consider what cognitive distortions may be at play.

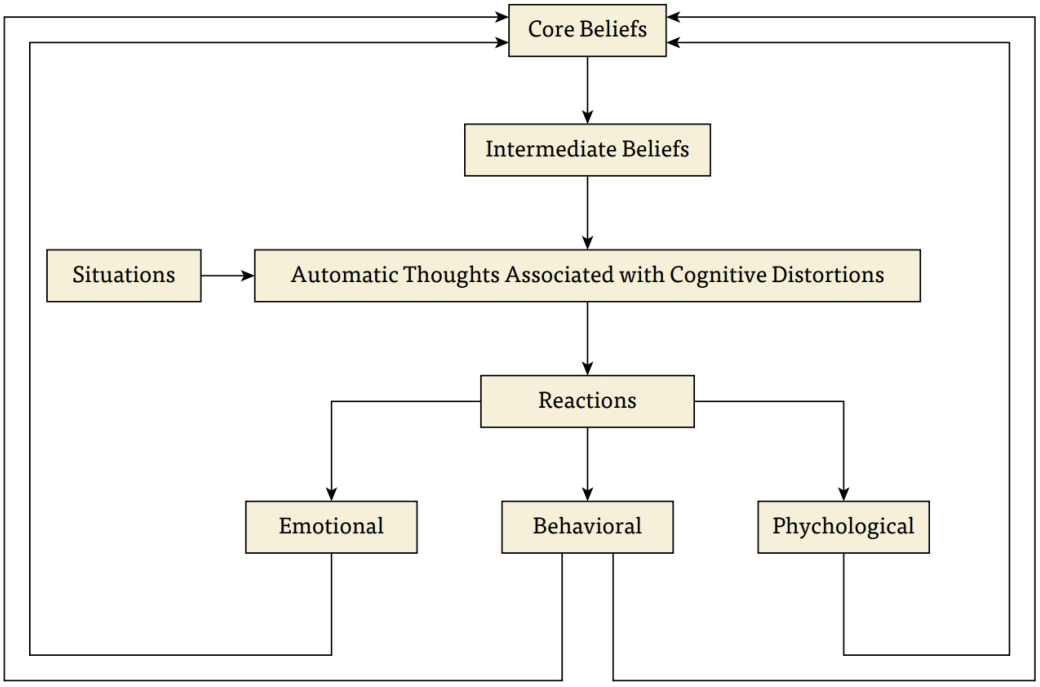

FIGURE 9.3 Relationships Between Core Beliefs, Intermediate Beliefs, and Automatic Thoughts

Coping or Compensatory Strategies

Individuals who have negative core beliefs want to protect themselves from the pain such beliefs will inherently cause them (J. Beck, 2005, 2021). Thus, they develop *coping strategies* (also known as *compensatory strategies*) to steer them away from their negative core beliefs. For instance, a person with a core belief that they are inadequate might develop the strategy of overachieving in an effort to steer oneself away from feeling inadequate. Or an individual who feels powerless might compensate by trying to become all-controlling. Such strategies are remarkably similar to Adler's compensatory behaviors used to avoid feelings of inferiority (see Chapter 4). Perhaps, it is not by chance that Beck developed these ideas after having been enamored, earlier in his life, by the Adlerian approach to counseling (Weishaar, 1993).

Generally, coping strategies develop early in life and allow individuals to avoid dealing with the strong negative feelings that are a result of their negative core beliefs. However, these behaviors do not rid the person of their negative core beliefs, and often, over time, they become increasingly maladaptive for individuals. For instance, consider two individuals. The first one is constantly striving to achieve in order not to feel inadequate, and the second is always trying to control others because they feel powerless. Over time, the first person might become more stressed as they compulsively try to achieve, while the second person would likely have difficulty in relationships

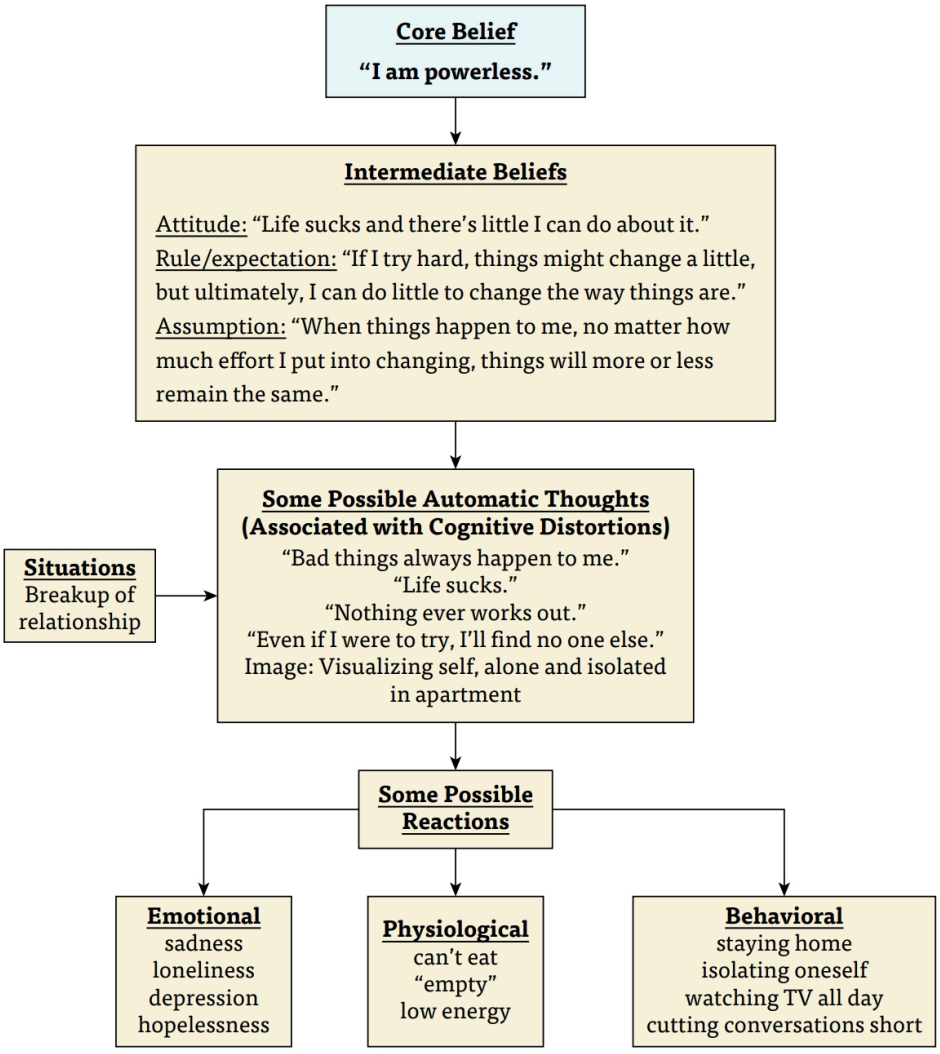

FIGURE 9.4 Example of the Relationships Between Core Beliefs, Intermediate Beliefs, and Automatic Thoughts

BOX 9.4 Deciphering Your Core Beliefs

Using Figure 9.5 as a template, consider your major childhood events and reflect on your emotions and automatic thoughts to determine what core beliefs might be driving your feelings and behaviors.

because they are constantly trying to control others (controlling behaviors do not work well in relationships).

Figure 9.5 shows the relationships between core beliefs, intermediate beliefs, coping strategies, automatic thoughts, and resulting feelings for a client described by Judith Beck (2005). In addition to the emotions the client would experience (lowest boxes). You can probably imagine the kinds of behaviors that will result from this person's core beliefs and coping strategies (see Box 9.4).

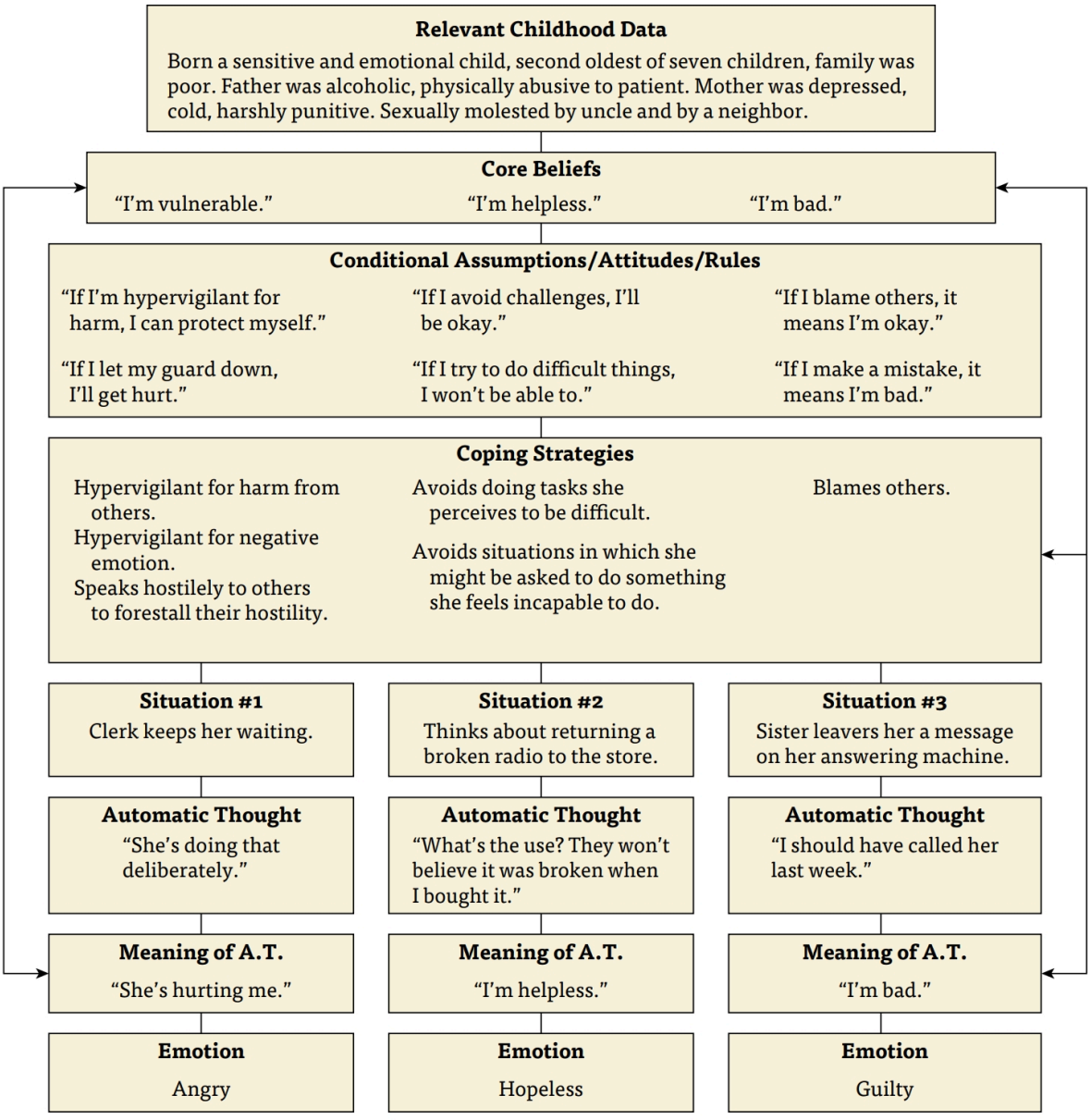

FIGURE 9.5 Relationships Between Beliefs, Coping Strategies, Automatic Thoughts, Behaviors, and Feelings

Cognitive Conceptualization

> A distinctive feature of Beck's CT theory is the cognitive specificity hypothesis which proposes a distinct cognitive profile for each psychiatric disorder. (Tower, 2011, p. 30)

Over the years, Beck and others have suggested there are distinct cognitive processes and behavioral patterns that characterize varying psychological disorders (Beck Institute, 2021d; Beck & Haigh, 2014; J. Beck, 2021). Therefore, if the counselor can accurately assess a client's disorder, then specific automatic thoughts and associated cognitive distortions, intermediate thoughts, and

core beliefs can be inferred. In addition, treatment plans can be matched to the specific disorder and to the cognitive processes that parallel the disorder, increasing the likelihood of success in counseling. Thus, from the moment the counselor meets the client, a process begins in which they elicit information from the client, so they can hypothesize about the kinds of automatic thoughts, intermediate thoughts, and core beliefs that have been developed and continue to fuel the client's presenting problems. Several activities can help in this process, including the following:

- gathering important childhood data (understanding a person's history can help identify beliefs that have been developed)
- accurately identifying client problems (certain problems lend themselves toward certain kinds of beliefs)
- determining the client's diagnosis (diagnoses tend to correlate with specific beliefs)
- having the client identify automatic thoughts and cognitive distortions (specific automatic thoughts and cognitive distortions are associated with underlying beliefs)
- identifying resulting emotions, physiological responses, and behaviors related to the automatic thoughts (responses tend to cluster as a function of specific beliefs)
- identifying past and current stressors that might have led to the development of specific beliefs

Therapeutic Techniques

More than most therapies, CBT has a host of essential and commonly used techniques that therapists can apply based on the diagnosis and presenting problem of the client. Regardless of the techniques, *14 basic principles* are core to the therapeutic process, and include (J. Beck, 2021):

1. CBT treatment plans are an ever-evolving cognitive conceptualization.
2. CBT requires a sound therapeutic relationship.
3. CBT continually monitors client progress.
4. CBT is culturally adapted and tailors treatment to the individual.
5. CBT emphasizes the positive.
6. CBT stresses collaboration and active participation.
7. CBT is aspirational, values based, and goal oriented.
8. CBT initially emphasizes the present.
9. CBT is educative.
10. CBT is time sensitive.
11. CBT sessions are structured.
12. CBT uses guided discovery and teaches clients to respond to their dysfunctional cognitions.
13. CBT includes Action Plans (i.e., therapy homework).
14. CBT uses a variety of techniques to change thinking, mood, and behavior. (pp. 16–17)

Essential Techniques

These techniques, used by most cognitive therapists almost all the time, include building a strong therapeutic alliance, educating the client about the cognitive model, Socratic questioning,

identifying and challenging automatic thoughts and images, identifying and challenging cognitive distortions, identifying intermediate beliefs, identifying and challenging core beliefs, and doing homework assignments (see J. Beck 2021; Dobson, 2012; Neuman, 2016; Rice, 2015).

Building a Strong Therapeutic Alliance

Cognitive therapists believe that *building a strong therapeutic alliance* is critical for effective outcomes in counseling. A number of ways to accomplish this include *being collaborative*; *demonstrating empathy, caring, and optimism*; and *adapting one's therapeutic style to the client's needs*.

- **being collaborative:** Being collaborative, or viewing the counselor–client alliance as a team, is key to the therapeutic alliance. However, it is also understood that the counselor has expertise and can help guide the client toward certain ways of thinking and acting. Thus, it is usual for therapists to make suggestions, while respecting the client's opinion and feedback. In fact, at the end of each session it is common for CBT therapists to ask their clients such things as, "How has this session been for you?" "Does what we did today make sense to you?" or "Are the goals we set in sync with where you think we should be going?"
- **demonstrating empathy, caring, and optimism:** These basic counseling skills are important for most forms of therapy. For the CBT counselor, who can easily slip into a role of objective scientist, it is particularly important to remember not to view counseling as a "clinical process" but as a joint therapeutic venture in which two people are sitting together in an effort to help one of them feel better. Clients who work with detached, objective scientists would be more likely to give up than clients who work with counselors who show deep understanding and caring and who are hopeful about their clients' future.
- **adapting one's therapeutic style**: Cognizant of the fact that clients respond differently to varying personality styles, Judith Beck suggests that therapists adjust their style based on how the client presents to the therapist. For instance, while some clients find they like a "touch feely" therapist, others might be more comfortable with a therapist who is a bit more directive. It is important to change one's style in an effort to help the client feel comfortable within the therapeutic relationship.

Educating the Client About the Cognitive Model

Early on in counseling, counselors *educate their clients about the cognitive model* (Beck, 2021; Dobson, 2012). Starting with the basics, therapists explain automatic thoughts and help clients identify the automatic thoughts they might be having. Often, graphics such as those in Figures 9.2 through Figure 9.5, can be used to help facilitate this process. Education should be an ongoing process as clients become more adept at understanding the cognitive model. Spending a great deal of time helping clients understand core beliefs early in counseling may be futile, but focusing on automatic thoughts during early sessions can be helpful, as most clients will "get it." And as clients learn and apply this cognitive model to themselves, they will eventually gain an understanding of how their thoughts, feelings, and behaviors are related to their core beliefs, and they can then begin the challenging work of changing them.

Socratic Questioning

Gently challenging clients to think differently and rationally about their situation to illuminate alternative ways of understanding predicaments is core to the *Socratic questioning* process. Conducted with a helpful spirit, such questioning is mostly used after the relationship has been

established to identify and challenge the client's use of dysfunctional automatic thoughts and cognitive distortions, rigid rules and assumptions, and negative core beliefs.

Identifying and Challenging Automatic Thoughts and Images

Because counselors applying CBT "work backwards" toward helping clients see how their core beliefs affect the very basis of who they are, the first step after building the relationship is to help clients identify their *automatic thoughts and images* (Beck, 2021; Newman, 2016). These thoughts and images are the most readily understood aspect of the cognitive model because clients can easily "catch" them and because they can quickly see the direct connection between their thoughts and their negative feelings and dysfunctional behaviors. For example, the client who has just broken up with their lover comes in feeling depressed. After gathering basic information, the counselor might ask the client:

- "Are you aware of anything that you are saying to yourself that may be causing you to feel this badly?"
- "Can you imagine what kinds of self-statements, thoughts, or images you are having that could cause you to feel this way?"
- "Have you noticed any thoughts or images you have that kind of drift through your mind while you have been feeling this way?"

As clients become more aware of their automatic thoughts, counselors can gently challenge their rationality. For example, if a client has an automatic thought such as, "I am not as smart as my coworkers," which leads to feelings and behaviors that are self-destructive (e.g., feeling unmotivated and not working hard), which then results in poor supervisor evaluations, the therapist might ask such questions as:

- "Are you really not as smart as your coworkers?"
- "What evidence do you have that you're not as smart as your coworkers?"
- "My experience has been that people have different strengths. What are your strengths at work?"
- "How might this belief stop you from being smarter?"
- "What do you think your life would look like if you didn't have these thoughts?"

Identifying and Challenging Cognitive Distortions

Because automatic thoughts are often based on one or more cognitive distortions noted in Box 9.3, after identifying automatic thoughts, therapists will generally *identify and challenge cognitive distortions* (J. Beck, 2021; Neuman, 2016). Identifying cognitive distortions is often completed by simply handing the client the list of distortions and reviewing it with them. After one or more distortions have been identified, the therapist and client will often engage in a discussion about the irrationality of such distortions and how changing one's automatic thoughts can be helpful in moderating or eliminating the cognitive distortions and their debilitating results.

Identifying Intermediate Beliefs

Once clients can identify and challenge their automatic thoughts and associated cognitive distortions, they can move to the next level of beliefs by *identifying intermediate beliefs*. This is accomplished by examining the attitudes, rules and expectations, and assumptions that drive their thoughts

and associated distortions. Often, a worksheet, such as that used in Figure 9.4, can be helpful for the client, as the therapist tests out hypotheses with the client about the kinds of attitudes, rules and expectations, and assumptions that tend to run their life. Identifying such beliefs moves the client toward the next phase of therapy, which is identifying and challenging core beliefs.

Identifying and Challenging Core Beliefs

Usually, seamless movement occurs from the client's awareness of their attitudes, rules and expectations, and assumptions (intermediate beliefs) to *identifying and challenging core beliefs* that created them. Thus, as soon as intermediate beliefs are acknowledged, the therapist shows the logical connection between those beliefs and the client's core beliefs. The next challenge is to confront the core beliefs. One method of doing this is by completing a core belief worksheet in which the client identifies a negative core belief, highlights a new positive core belief that the client can strive toward, and shows evidence that contradicts or reframes the client's old core belief and moves the client toward the new positive core belief. For instance, look in Box 9.5 to see how Juan contradicts his old core belief: "I am ineffective."

BOX 9.5 Core Belief Worksheet

Old core belief: "I am ineffective."

"How much do you believe the old core belief right now?"	(0–100): 25%
"What's the most you've believed it this week?"	(0–100): 55%
"What's the most you did *not* believe it this week?"	(0–100): 90%

New belief: "I am pretty good at most things I do, and I usually try hard."

"How much do you believe the new belief right now?"	(0–100): 75%

Evidence Contradicting Old Belief/ Supporting New Belief

- Went to daughter's child–parent conference
- Helped kids with homework
- Spent time making children their lunches
- Researched an important paper for work
- Boss praised me three times
- Kids gave me lots of hugs this week
- Wife told me I'm a great father
- Worked hard to fix things around the house
- Took kids and wife bowling

Reframing Old Belief

- Had trouble understanding new project at work, but I asked for help from coworkers and believe I am capable of understanding it and doing a good job.
- Only put the kids to bed once this week, but had a hard week at work, and wife and kids didn't seem to mind. I can do more next week, and I have other signs that I am a good dad.
- Couldn't fix the broken back door, but I realize I'm not perfect at everything, and I did a lot of other things around the house this week.

Note. Adapted from *Cognitive therapy: Basics and beyond* (3rd ed.), by J. Beck, 2021, pp. 303–321. Copyright 2021 by Guilford Press.

Homework

An active, ongoing process, *homework* reinforces new beliefs and facilitates client movement toward managing their own problems (Rice, 2015). Homework often progresses from catching automatic thoughts and images to challenging automatic thoughts and images to challenging intermediate beliefs and, finally, to challenging core beliefs. Homework assignments can also be the practice of new behaviors, which are generated to reinforce newly identified beliefs. For instance, the individual who has the automatic thought that "I am horrible at talking with people" may have the homework assignment of finding five strangers to talk with during the week in addition to developing new thoughts, such as "I am as good as most when talking with others." There are hundreds of different kinds of homework assignments that can be given, and all the "commonly used techniques" highlighted in the next section are frequently used in this manner.

Commonly Used Techniques

The following represent just a few of the techniques commonly used by many cognitive therapists much of the time. They include thought stopping, imagery changing, rational–emotional role-play, and behavioral and emotive techniques.

Thought Stopping

A major strategy of CBT is for the client to realize that automatic thoughts are related to negative feelings and dysfunctional behaviors (Bakker, 2008). Thus, it is often suggested that clients find ways to prevent their negative thoughts. One method of doing this is through *thought stopping*, which can be accomplished in a variety of ways, such as the following:

- replacing a negative thought with a newly identified positive one
- yelling to oneself, out loud, "Stop it!" when a negative automatic thought is identified
- placing a rubber band on one's wrist and snapping it whenever one has a negative thought
- actively diverting one's thoughts to more pleasant thoughts
- participating in a relaxation exercise to "move" one's thoughts to a different place

Imagery Changing

As noted earlier, like thoughts, mental images are a product of one's core beliefs and can produce distressing feelings and dysfunctional behaviors. To address disturbing mental images, several techniques have been developed. Using the following scenario, eight *imagery-changing* techniques are described (J. Beck, 2021).

> Vanessa has a bridge phobia and becomes extremely anxious when driving over a bridge. Even when her husband is driving, she begins to get panicky as they get close to a bridge. As they drive over, she begins to have images of her husband losing control of the car and the car veering off the side of the bridge and plunging into the water. She sees them struggling to get out of the car as it fills with water. Her heart beats frantically as they drive over the bridge, the images deeply embedded in her mind.

1. **following images to completion:** In this technique, the Vanessa tells the story about the image to its completion. Generally, one of two things happens: either she resolves the story (e.g., Vanessa sees them crashing off the bridge, then looks at the counselor, and says, "This is really silly—this will never happen" and begins to challenge the image), or the image is

taken to its catastrophic end, which provides important new material the client can work on (e.g., Vanessa sees herself and her husband dying in the crash and worries about what will happen to the children—the underlying concern in the image is worry about ensuring her children's safety).

2. **jumping ahead in time:** In this case, the client jumps ahead in time in an effort to "jump over" the distressing image. For instance, while driving over the bridge, Vanessa learns how to imagine herself safely at the end of the bridge.
3. **coping in the image:** Here we have Vanessa change the image to a coping image. For instance, as the couple nears the bridge, Vanessa imagines saying, "Can I drive? I love going over this bridge." Then, she can imagine herself driving over.
4. **changing the image:** In this case, the image is changed to one which does not result in distress. This can be done realistically or as a "magical" image. As an example of a magical image, Vanessa might see herself in a fancy convertible going over a golden bridge that has safety nets on the side to catch cars that could fall over. Her hair flows in the wind as they enjoy the ride over the bridge.
5. **reality testing the image:** Here the counselor uses Socratic questioning to bring the client "back to reality." For instance, the counselor might ask Vanessa, "What is the likelihood of this happening? Do you think your anxiety is in line with the probability that this will occur?"
6. **repeating the image:** By describing a distressing image multiple times, the image will often change on its own, sometimes becoming more subdued. For instance, when Vanessa is asked to continually describe the image of the car driving over the bridge, her anxiety slowly lessens to the point where she can imagine herself successfully making it over the bridge.
7. **image stopping:** Like thought stopping, this technique has the client use mechanisms to stop the image in its tracks. For instance, Vanessa might yell out, "Stop it!" as she begin to imagine the car veering off the road, or she might snap a rubber band they have placed around their wrist—the snapping being a signal to herself to stop imagining the car veering off the bridge.
8. **image distracting:** Here the client does something that is incompatible with the anxiety-producing image. So Vanessa might play Sudoku as she rides in the car. One cannot play Sudoku and be anxious at the same time. Or Vanessa might have a planned phone call to her supervisor to discuss a work situation at the time she knows she will be going over the bridge.

Rational–Emotional Role-Play

Even though clients will come to the realization that their beliefs are dysfunctional, many have difficulty counteracting them due to a strong emotional attachment to the belief (Beck, 2021). *Rational–emotional role-play* allows clients to have a debate between the rational and emotional parts of themselves. Often, the counselor will first debate the client by role-playing the rational part, while the client responds with the emotional, dysfunctional part. Then, to allow the client to counteract their own dysfunctional part, the counselor will switch roles with the client. The following role-play shows the first part of this process, with the counselor playing the rational part and the client playing the emotional, dysfunctional part. As you read it, consider what a client might take from such a role-play.

> *Counselor:* How about we role-play the emotionally dysfunctional and the rational parts of your dilemma around your feelings of being incompetent at parenting because

sometimes you lose your cool and yell at your children? I'll be the rational part, and you start by being the emotional, dysfunctional part. As that person, tell me how you feel about your parenting.

Client: I'm a horrible mother. I'm always screaming at my kids.

Counselor: I am not! Most of the time, I'm not screaming at my kids. In fact, most of the time, I'm a pretty good parent.

Client: Well, I may not be screaming at them all the time, but when I do, I know they just hate me, and I know it's not good for their self-esteem.

Counselor: I know that yelling is not the best thing, but I also know that it's only a small part of who I am as a parent, and I can put that part in perspective.

Client: My friends don't yell at their kids. They must be much better parents.

Counselor: I don't see my friends yelling at their kids as much as I do, but I also know that they have other issues with their kids. And besides, I'm in therapy working on my issues trying to better myself.

Client: Well, I still just don't feel good about yelling at my kids as much as I do.

Counselor: I don't like that I yell at my kids as much as I do, but I'm working on that, learning how to deal with my emotions, and learning other ways of responding. In fact, I'm pretty proud of myself for doing this.

Client: Well, yelling, even some of the time, is just a horrible thing to do.

Counselor: Certainly yelling less is better than yelling more. And let's not forget all the other times that I don't yell. Actually, usually I'm a damned good parent.

Client: Actually, that is true; I am good at those other times. I'm really empathic, nurturing, and caring with them.

Counselor: So we have a little bit of a broader picture here, don't we?

Client: Well, yes, I guess we do.

In the above role-play, notice the various cognitive distortions that make up the client's thinking process (see Box 9.3 to identify specific distortions). How can identification of such distortions and associated automatic thoughts help the client? With what core beliefs might this client be struggling? Also, consider what it would be like if the client and therapist switch roles with the client now being able to be the more rational, functional part of self.

Behavioral and Emotive Techniques

Throughout this chapter, we have discussed the connections between beliefs, automatic thoughts, and how one feels and acts. With negative automatic thoughts come negative feelings and dysfunctional behaviors. And it makes sense that if a client is to change their automatic thoughts,

they should also address the emotions and behaviors that have resulted from them. Thus, a multifaceted approach that includes addressing *behavioral and emotive techniques* can help the change process occur more rapidly.

For instance, the mother who insists she is a bad mother because she yells too much can begin to consider other ways of dealing with her feelings and changing her children's behaviors, so she does not feel compelled to yell. A behavioral approach for this mother could be to develop additional parenting skills, such as the use of a sticker chart. An emotive technique could be to yell into a pillow every time she becomes overwhelmed with her children. Yelling at your children does not make one a failure, but finding other ways to discipline one's children and deal with out-of-control emotions will make one a better parent.

As another example of a behavioral technique, consider the man who has a core belief that he is unlovable. From this core belief he has developed a set of behaviors that prevents him from getting close to people. As the person works on addressing his negative core belief, he can also approach his problem behaviorally. For instance, he might set a goal for himself of finding a support group through which he can meet others. And as an emotive technique, once he finds this group, he can have a secondary goal of sharing deeper feelings with some of the people in the group in an effort to develop intimacy.

There are literally hundreds of behavioral and emotive techniques that cognitive-behavioral therapists can use in conjunction with their cognitive techniques, including many of the techniques found in other theories throughout this text. Techniques used are only limited by the imagination of the counselor in consultation with the client. To find an appropriate technique, the counselor must have a good sense of the client's underlying cognitive processes (often deduced from a diagnosis and good client history) and then match an appropriate technique.

The Counseling Process

The therapeutic process can be seen as a series of stages that includes *intake and evaluation*, *the first session*, *the second and subsequent sessions*, and *termination*.

Intake and Evaluation

This first part of the therapeutic process, *intake and evaluation*, occurs prior to actual counseling taking place and is focused on doing a thorough assessment of the client. This process, which may or may not take place with the client's eventual counselor, helps the counselor orient themselves to the client's problem prior to the actual beginning of counseling. Broad goals for this first meeting with the client include the following (J. Beck, 2021):

- greeting the client and building the therapeutic alliance
- discussing the purpose and process of the session and setting the agenda
- conducting a mood check (e.g., "On a scale of 0 to 100, with 100 being extremely depressed, how depressed do you feel today?")
- conducting the assessment
- developing broad initial goals
- eliciting feedback from the client

Most of this session will be focused on the assessment process, which should cover a wide spectrum of the client's life (Beck, 2021; Neukrug, 2020). Some areas that are addressed in the assessment process are highlighted in Box 9.6.

BOX 9.6 Conducting the Assessment

The assessment process should have breadth and depth, and some of the areas that should be covered during this evaluation include the following:

- client demographics
- presenting problems and issues
- past and present coping strategies
- client and family psychiatric history
- family background
- social and cultural considerations
- developmental concerns
- substance use and abuse
- medical history
- family background
- educational and vocational history
- medical history
- mental status (e.g., appearance and behavior, emotional state, thinking process, and cognitive functioning)
- past and current diagnoses
- religious and spiritual background and important values
- strengths and coping strategies
- administering appropriate assessment instruments (e.g., Beck Depression Inventory II; Beck et al., 1996)

As the assessment process comes to an end, the counselor should begin to have a picture of the client's life and develop a tentative conceptualization of the client's belief system. Figure 9.5 can be helpful in understanding this process. Therapists can then seek feedback from the client about the therapist's understanding of the client's belief system and the readiness of the client to follow through on a tentative treatment plan. At this time, broad goals can be set (e.g., "alleviation of depression" or "getting along better with people at work").

The First Session

The structure of *the first session* varies from subsequent sessions because it focuses on building the relationship, instilling hope in the client, and educating and orienting the client to the cognitive model. J. Beck (2011, 2021) suggests the following structure for the first session to accomplish this:

1. **Conduct a mood check:** Here the therapist reevaluates the client with the same assessment instrument given during the intake or some accurate measure that can assess the client's mood (e.g., the Beck Depression Inventory; Beck et al., 1996).
2. **Set the agenda:** This part of the session involves the therapist informing the client about what will occur during the first session.
3. **Obtain an update:** Near the beginning of the session, clients should be asked whether they have any additional concerns, questions, or information to add since their first meeting. In addition, to ready the client for change, they should be asked about any positive experiences

they had since the last meeting. Such experiences can begin to focus them on the change process, and they begin to think about an action plan for change.

4. **Discuss the diagnosis:** Most clients would like a general sense of their diagnosis and to know that they are not crazy. Normalizing their experience allows clients to realize that others have experienced and successfully tackled similar problems in therapy. Although it is probably better not to identify a *DSM* diagnosis, offering a more general diagnosis (e.g., "You're pretty depressed" or "You see seem to be struggling with a phobia") can be quite helpful. At this point, it can also be helpful to offer readings or other resources, from a CBT perspective, that can help clients begin to understand what they are struggling with and how they can begin to tackle their problems.

5. **Educate the client about the cognitive model:** Here the counselor teaches the client the relationships among thoughts, feelings, and behaviors. Thoughts are broadly defined as what one is thinking about as well as images or pictures that pass through one's mind, and the therapist uses examples from the client's life to show that situations affect thoughts and that thoughts will often lead to strong feelings and actions. The therapist might also use a flowchart similar to the one displayed in Figure 9.6 to highlight this point.

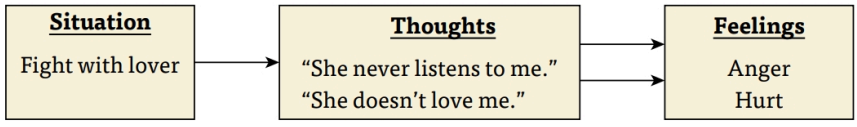

FIGURE 9.6 Situation to Feelings Flowchart

At this point, the focus is on teaching the client how to catch their automatic thoughts. Later sessions will focus upon cognitive distortions (and their relationship to automatic thoughts), intermediate thoughts, coping or compensatory strategies, and core beliefs.

6. **Identify values and aspirations:** Helping clients identify what is important to them and what they would like to aspire to is important for eventually settings goals, as you want such goals to be congruent with the client's sense of what they want in life. For instance, a client who wants to have a more loving relationship with their spouse and to be more productive and fulfilled at work may come to see how their depression has been inhibiting specific behaviors to achieve these desires. Thus, the counselor can help the client alleviate depression and set behavioral goals to meet these values and aspirations.

7. **Review presenting problem(s) and set goals:** Here clients begin to review the initial problems identified during the intake interview to ensure that no other issues need to be addressed. At this point, problems can be turned into broad goals. For example, a depressed client who is missing work and feeling lonely might have the broad goals of feeling less depressed, making new friends, having a more loving spousal relationship, and missing less time at work.

8. **Summarize the session and develop homework assignments:** Near the end of this session, the therapist summarizes what was talked about and collaboratively develops some tasks the client can work on at home prior to the next session. Tasks should be achievable, and if the therapist senses that the client will not work on one or more specific tasks, they should modify the task(s) or come up with others.

9. **Provide an end-of-session summary:** Summarizing the client's sessions helps them organize their thoughts, remember salient points, and be ready to work on their homework assignments.
10. **Ask for feedback:** Asking for feedback helps to reinforce the collaborative nature of the relationship and assures that the therapist is on target with the direction of therapy. Feedback can be asked for orally, but Judith Beck (2011) also suggests that the following kinds of questions can be responded to in writing:
    - What did you cover today that's important for you to remember?
    - How much did you feel you could trust your therapist today?
    - Was there anything that bothered you about therapy today? If so, what was it?
    - How much homework had you done for therapy today? How likely are you to do your homework?
    - What do you want to make sure to cover at the next session? (p. 77)

Information from the initial intake and the first session allows the counselor to put the pieces of the puzzle together as they complete all aspects noted in Figure 9.5. This allows the counselor, and eventually the client, to increasingly understand how the client's history, belief system, coping strategies, and automatic thoughts affect the client's daily life.

The Second and Subsequent Sessions

The second and subsequent sessions are focused on strengthening the therapeutic alliance, symptom relief, and obtaining a deeper understanding of the cognitive model. In that light, the counselor hopes to continue to familiarize the client with the CBT model, work collaboratively, help the client solve identified problems, and as symptom relief is obtained, work toward termination. As sessions continue, this work becomes increasingly focused, as the pieces of the puzzle, as highlighted in Figure 9.4, are completed. Judith Beck (1995, 2011, 2021) suggests the following structure for the second and subsequent sessions:

1. **Conduct a mood check:** Here the therapist checks in with the client to see how they have been doing since the last session. In addition to gathering verbal feedback, the therapist asks the client to retake the same instrument that was taken during their last session (e.g., Beck Depression Scale) and/or to conduct a subjective mood check (0–100). In this manner, the therapist can assess progress toward goals.
2. **Set the agenda:** In the earlier sessions, the therapist sets more of the agenda as they identify problems to focus upon and teach the client about the cognitive model. As the client learns more about the model, as well as techniques that can be used to address cognitive distortions, coping strategies, and negative core beliefs, it is the client who increasingly sets the agenda.
3. **Review the homework:** Compliance in doing homework is facilitated by the therapist's review of all homework assignments. When a homework assignment has not been completed, it is important for the therapist to understand the reason it was ignored. Not completing a homework assignment due to a family emergency is quite different from ignoring one because the goals were inappropriate. As sessions continue, the client takes more responsibility for developing their own homework assignments.
4. **Shift from automatic thoughts to intermediate and core beliefs:** As sessions continue, the client should become increasingly familiar with the cognitive model and can begin to

understand intermediate and core beliefs and begin the process of disputing them. This process occurs through mental disputations as well as behavioral changes.

5. **Ask for feedback:** As in the first session, feedback is critical in every session if the client is to feel as if they are a collaborator and if therapy is to be on track (see The First Session).

Termination

Because it is predicated on the alleviation of identified symptoms, CBT tends to be short-term, and from the very first session, there is an eye to the last session and *termination* from therapy. Although the therapist takes a more directive and educative role early on in this process, as the client increasingly learns how to work independently on their issues, the counselor takes a lesser role. Figure 9.7 graphically depicts this process.

As counseling continues, the counselor should expect client setbacks, as the client struggles to work on their problems and as the hypotheses that originally were formed become slightly changed. As the client nears the last session, the counselor should explore the client's thoughts about termination and help them develop a process in which they are conducting self-management sessions.

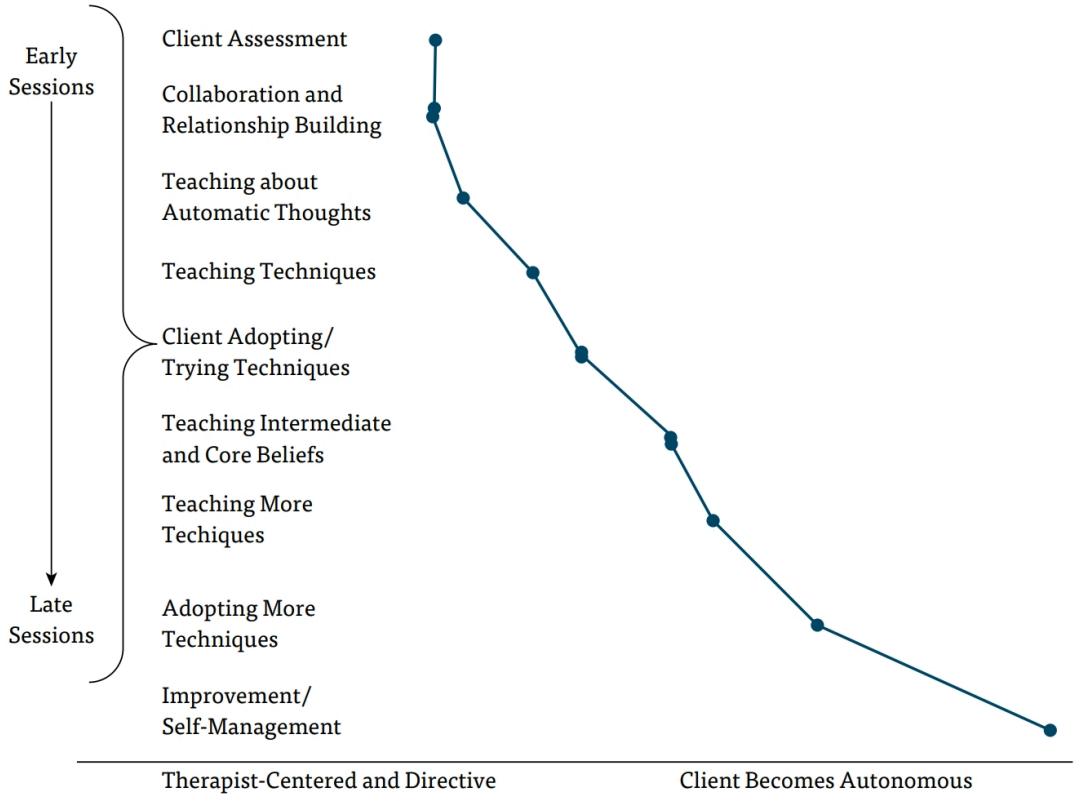

FIGURE 9.7 Movement of Client Toward Termination Over Sessions

Social, Cultural, and Spiritual Issues

The early days of CBT saw research on its effectiveness mostly conducted on White people, focused little on cultural factors, and offered little explanation as to how to work with diverse clients.

However, in recent years, we have seen a dramatic shift in CBT scholarship that focuses on its application to culturally diverse populations (Beck, 2016; DeAngelis, 2015; P. Hays, 2014; Naeem et al., 2019).

According to recent CBT scholarship, a client's cultural identities, values, and social experiences influence the core beliefs and assumptions they have about themselves and others, their understanding and experience of psychological distress, as well as their views on psychotherapy and other systems of care (Iwamasa & P. Hays, 2019; Rathod et al., 2015; Wenzel et al., 2016). Given the linkage among culture, marginalization, symptomology, and health care utilization, it is important that social, cultural, and spiritual issues are considered when determining how CBT is delivered to culturally diverse clientele.

CBT can be especially effective when social, cultural, and spiritual issues are attended to during all phases of the therapeutic process (Beck, 2016; Naeem, 2019; Wenzel et al., 2016). It is particularly well-suited for cross-cultural counseling because it emphasizes the following (Steele, 2020; Wenzel et al., 2016):

- the tailoring of interventions to the individual client,
- the client's expertise about themselves as well as their capacity to learn from therapy and apply that learning to future challenges,
- conscious processes that can be taught to a range of clients, including those with language barriers,
- an understanding of cultural strengths and supports that can be used to reinforce desired thoughts, feelings, and behaviors,
- the connection between environment and behavior, given CBT's roots in behaviorism (e.g., how racism and discrimination can reinforce certain behaviors), and
- an emphasis on personal power, client strengths, client support systems, and the affirmation of the client's identity.

Like other approaches, counselors need to be aware of their own cultural biases (Wenzel et al., 2016). Self-examination of their own biases around culture, privilege, and oppression can help counselors work more effectively with all clients. For example, Naz et al. (2019) suggest that therapists examine their own implicit bias and resulting behaviors, many of which can be related to cognitive distortions (e.g., labeling, overgeneralization, all-or-nothing thinking, etc.) and related automatic thoughts and ask themselves the following questions:

- "Am I knowledgeable enough to understand the ethnicity/culture/religion of diverse clients?"
- "How might questions around my clients' ethnicity, culture, or religion be related to my own prejudices?"
- "How might my automatic thoughts and core beliefs be related to unconscious bias?"
- "What kinds of biases (e.g., cognitive distortions) do I carry that can impact my work with clients?"

As counselors realize their biases they can more accurately acquire knowledge of their clients' worldviews and experiences, tolerate uncertainty and vulnerability within themselves, and be open to supervision (Naz et al., 2019).

Culturally adapted CBT (CA-CBT) is one method used when considering social, cultural, and spiritual issues when employing CBT. Andrew Beck (2016) noted that CA-CBT more intentionally grounds the intersectional cultural identities possessed by culturally diverse clients into the therapeutic process; it incorporates cultural idioms of distress, language and cultural metaphors and values, oppression experiences, and level of acculturation and migration history into traditional

CBT components—and, thus, adapts the approach to a specific culture. In addition, CA-CBT involves a comprehensive cultural assessment and engagement process, adapts treatment techniques and makes other therapeutic adjustments as needed (including adapting treatment manuals), as well as considers the capacity and characteristics of the local health care system (Naeem et al., 2019). Research on CA-CBT indicates its adaptability to different cultures is effective at reducing psychological symptoms such as depression, anxiety, psychosis, and interpersonal difficulties (Rathod et al., 2015; Wenzel et al., 2016).

Iwamasa and P. Hays (2019) offers a framework for those using CBT in their practice with clients of marginalized statuses. They use the acronym *ADDRESSING*, in which each letter signifies an area of identity that is important to explore with clients:

- **A:** age and generational influences
- **D:** developmental
- **D:** acquired disabilities
- **R:** religion and spiritual orientation
- **E:** ethnicity
- **S:** socioeconomic status
- **S:** sexual orientation
- **I:** indigenous heritage
- **N:** national origin
- **G:** gender

Counselors using CBT distinguish between oppressive systemic stressors and situational cognitive stressors within the client's control. P. Hays (2009) recommends that counselors who use CBT validate a client's experience of oppression and assist clients in identifying culturally related strengths and supports. In addition, using the acronym *CLASS*, P. Hays (2014) describes five domains counselors should consider when introducing CBT interventions with culturally diverse clients:

- **creating a healthy environment:** Consider available options within the client's environment, and introduce possible changes within their social and physical environment that can reinforce desired behavior.
- **learning something new:** Empower the client to learn a new skill, habit, or information that incorporates their culture or worldview.
- **assertiveness, conflict resolution, and other communication skills:** With an awareness of culturally specific relationship norms, teach clients about these skills.
- **social support:** Encourage clients to involve others in their therapeutic process as they feel comfortable, as well as reflect with the client ways in which potential or currently available social, cultural and spiritual support systems can be beneficial to enacting desired therapeutic changes.
- **self-care activities:** Explore with clients a broad range of self-care activities that can address multiple areas of wellness (e.g., physical, emotional, and spiritual) that do not require money and are accessible to them.

Furthermore, Steele (2020) provides a CBT-based model for assisting clients of color who have internalized negative messages about race/ethnicity and other cultural identities. Here ounselors can educate them on how automatic thoughts and images have been shaped by systemic oppression and what compensatory or coping strategies are being used to influence current cognitions, behaviors, and emotions. Then, they can use this information to increase client awareness of the influence of systemic oppression on their current psychological distress; challenge negative

thoughts, behaviors, and emotions; and empower clients to modify these negative outcomes, while providing them with culturally responsive behavioral and cognitive interventions.

Relative to one's religious beliefs and spirituality, how these impact one's belief system can vary dramatically as a function of one's religion or spiritual orientation. For instance, some individuals believe that one's belief system is mostly a function of internal structures in interaction with experiences, while others believe that the spiritual world *directly* affects their lives (Iwamasa et al., 2006; G. McAuliffe, personal communication, February 8, 2022). Clearly, such disparate beliefs will affect how a therapist works with the client. As with cross-cultural issues, cognitive behavior therapists need to understand how the client comes to understand their religion and spirituality and make necessary changes to their approach based on this understanding.

Efficacy of Cognitive Behavior Therapy

CBT is a short-term, structured, evidence-based practice, and one of the most used culturally adapted psychotherapy (Rathod et al., 2019; Wenzel et al., 2016). It uses a case conceptualization process in which the therapist assesses the client and then applies a specific treatment plan based on this assessment. In addition, instruments to assess and measure progress in treatment have been developed. Thus, assessing the effectiveness of CBT can seem rather straightforward: assess, apply your model, and use your instrument to measure change.

CBT has become one of the most popular treatments to address a range of mental health issues across a broad range of clients. According to the Beck Institute (2021e), more than 2,000 studies demonstrate CBT's efficacy for reducing psychological and psychiatric symptomology. Systematic reviews and meta-analyses (e.g., Dickerson et al., 2018; Hofman et al., 2012; Turner et al., 2014; Wiles et al., 2016; Wykes et al., 2008) highlight that CBT has been shown particularly effective with disorders and conditions in Box 9.7.

BOX 9.7 Common Conditions Treated With Cognitive Behavior Therapy

anorexia	fibromyalgia	panic disorder
bipolar disorder	generalized anxiety disorder	personality disorders
bulimia	health anxiety	post-traumatic stress
disorder	chronic fatigue syndrome	irritable bowel syndrome
schizophrenia	chronic pain	migraine headaches
social anxiety	Colitis	Obesity
substance use disorders	Depression	obsessive compulsive disorder

Furthermore, individual scholarship as well as systematic reviews of case study research indicate that CBT is effective in decreasing symptomology and improving social and familial functioning among culturally diverse clients, including those from international contexts (see Jones et al., 2018). Cross-cultural research reflects CBT's utility with individuals, families, and students (e.g., Alatiq & Alrshoud, 2018; Berry et al., 2018; Ginsburg & Drake, 2002; Wilson & Cottone, 2013). When culturally specific modifications are made in therapy, culturally diverse clients reported more positive cognitive, affective, and behavioral outcomes across settings, which were maintained over time (Castaños-Cervantes, 2019; Jankowska, 2019; Li et al., 2017; Naeem et al., 2014; Naeem et al., 2015; Rathod et al., 2017, 2019).

Although the effectiveness of CBT shows promise for work with a wide range of clients, meta-analyses using models such as CA-CBT (discussed in previous section) include studies with widely varying designs, study characteristics, and degrees of rigor (Beck, 2016). In addition, Rathod et al. (2015) note that what CA-CBT "looks like" for individual clients from a multitude of intersecting cultural identities and experiences is minimally described in the scholarship. Are CA-CBT approaches at risk of overgeneralizing or stereotyping clients of particular marginalized identities? What is their fidelity and effectiveness? Are new and more tailored approaches (rather that adapted ones) more suitable for particular clients? Clearly, many questions still prevail in efficacy research on CBT.

Despite some reservations, most would agree that CBT is effective with a wide range of mental health problems and a wide range of clients. Yet there is a "but" as it appears that *all* approaches are pretty much equally effective. Well at least that is the result of a massive review of the research by Wampold (2015, 2019). Reminiscent of Rosenzweig's 1936 research, when he said, "All methods of therapy when competently used are equally successful," Wampold finds that his quote stands up to today's rigor and reminds us that Rosenzweig called this the *Dodo bird effect* (see Box 9.8).

BOX 9.8 The Dodo Bird Effect

The Dodo was a character in Lewis Carroll's (1918) book *Alice in Wonderland*. Issuing a competition to a number of characters who had gotten wet, the Dodo tells them to run around a lake until they were dry. After doing so, they wanted to know who had won. His response was: "EVERYBODY has won, and all must have prizes" (p. 34). And so it is with approaches to counseling and psychotherapy!

The Millers

The following shows Ann's going through CBT. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Ann Meets With a Cognitive-Behavioral Therapist

Ann sat in the lobby arranging and rearranging the items in her bag. She had completed an intake form and a short questionnaire about her feelings of depression and anxiety and considered thumbing through one of the parenting magazines on the coffee table as she waited for the counselor Jake had recommended, Carol Allen, to emerge from their office. Ann looked at the family sitting stiffly on the couch directly across from her and offered a weak smile. Carol, a round-faced woman with graying hair and soft wrinkles around her eyes, smiled at Ann and invited her into the office. Ann was already crying before Carol was able to shut the door.

"I don't know where to start, so I'm going to start in the middle, or maybe at the end, I don't know. Two months ago I had my 65th birthday. It has hit me like a ton of bricks. It just got me thinking about my life." Ann paused a moment, reached inside her purse, and then, thinking better of it, set her purse aside. "There was a birthday party. My husband, Ted, and my children, Jake and Justine, were there. Jake's wife Angela and my grandchildren, Luke and Celia, were there, too, of course. Evangeline and Dexter, Angela's parents, helped Ted set up the whole thing. A lot of my old friends came, too, and even some of my piano students from way back and then—this is what got me, I think—Justine brought a boyfriend."

"Your daughter, she brought a man with her. What was it about Justine's date that troubled you?" Carol asked.

"Well, Justine moved out of the house last year and into a group home. She had an accident as a child that left her with—I can never quite get this out— she's retarded. This man she was with, Carl, he lives in the group home, too. He has Down syndrome," Ann explained. "That wasn't what

bothered me, though. It was just seeing all my friends and catching up on their lives and watching Jake with his kids and Justine with Carl. I should have been happy for everyone, but to tell the truth, I just felt really cheated. Here I am, 65 years old, and I was robbed of my children's childhood, robbed of a career, and now I'm just left behind. Everyone has their lives, their families and careers, and I—I have nothing to show for my life! Even Justine has a life of her own now, after years and years of having only me." Ann wiped the tears from her cheeks.

"Ann, when you saw your daughter at the party with Carl, can you remember the first thing that popped into your mind?"

"Yes, I thought, 'This is not how it's supposed to be.' I know how selfish that sounds." Ann paused and added, "I have always felt it was unfair that my friends' children grew up without the kinds of troubles that Justine had. And I spent so much time tending to Justine after the accident that my relationship with Jake fell apart. We were so close before, but there's been a distance ever since the accident. Also, I just never could move on with my career. You know, I had been a piano teacher, and I was hoping to eventually go back to that—my dream had been to start a music school. But Justine just took up so much of my time."

"Have you noticed what kinds of feelings you experience when those thoughts of things not being the way they should be move across your mind?" Carol asked Ann, handing her a box of tissues.

"Sadness, then sometimes anger and regret." Ann wiped her wet cheeks and blew her nose. "I get so depressed that things didn't work out the way that they were supposed to."

"I felt that from you, Ann, a lot of sadness, regret, and anger, and it sounded like there were feelings of being helpless, too, like you were just pushed around by the tide of events and left standing on the shoreline alone." Carol allowed some silence before continuing. "Ann, how often do you think that you have thoughts of how things should have been different?"

"A lot. It was one of the first things I thought about after the doctor told us that Justine had a brain injury and that she wasn't going to recover from it. I remember Ted and I drove home after that consultation with the doctor and the streets were crowded with cars, children in the neighborhood were running round outdoors, and people were playing tennis at the tennis court. It was like nothing had happened. Our world was crumbling, and the rest of the world seemed completely untouched. I remember thinking, this is so unfair." Ann paused a moment. "I find myself thinking about how unfair life is a lot."

"You and Ted and your children have been dealt a rough hand, that's for sure. There is a part of me that agrees with you—what happened in that accident wasn't fair; it was a tragedy. But it seems to have cast a shadow over your whole life. What I would like to do today is talk about how those thoughts you have—I call them your 'automatic thoughts'—affect so much of your life and cause you to feel the way you do. But before we go on to talk some more about automatic thoughts, I'd like to switch gears for a moment. If it's alright with you, I'd like to take some time going over your intake form and together try to get a sense of where you are right now and hopefully end with some goals for our coming sessions."

After covering more of Ann's history and evaluating her functioning, Carol ended the session by educating Ann about automatic thoughts and their connection to the feelings and behaviors that trouble most people. Carol and Ann explored the feelings Ann experienced when the thoughts of the world being unfair came to mind. Ann agreed to be mindful of the times when these thoughts arise in her mind and to make a note about it. Together, Ann and Carol agreed that in their next session they would work on ways to replace Ann's automatic thoughts with thoughts that are more productive for her and less distressing. Carol also provided Ann with readings about automatic thoughts and thought-stopping strategies.

When Carol and Ann met for their next session, Carol noticed a difference in Ann. "Your eyes look brighter than they did last week, Ann. How did your week go?"

"It was better than the week before; I was busy with some projects at church, so I was distracted. I did my homework, though." Ann reached into her purse and produced a small notebook, which she passed to Carol along with the mood questionnaire form she was asked to fill out as she waited for the session to begin. "I took notes on the reading that you gave me, and I kept a little log of my thoughts."

"Oh, this is great, Ann," Carol said as she flipped through the notebook. "And according to your questionnaire, your mood seems to have improved some since last week. It seems that something about our last session was helpful to you. Can you tell me what that was?" Carol asked, creating a bridge between their first session and this one.

"I think it helped a lot to just get some of those feelings out. I just don't think I could say those things to Ted or to any of my friends. But talking about those automatic thoughts was a 'light bulb' moment for me. I have been carrying those thoughts around with me for 30 years, and they really do influence my feelings. When I was writing my log I noticed that when I have those thoughts and then start to feel angry, I really take it out on Ted. I didn't realize how much time I spend criticizing him, but I do," Ann confided. "Other times, I just get depressed."

As the session continued, Carol began to connect Ann's automatic thoughts to a number of cognitive distortions, which they described to Ann, including catastrophizing, discounting the positive, tunnel vision, and overgeneralization. As the session came to a close Carol offered Ann some homework techniques to use to combat some of their automatic thoughts and images.

Over the next few sessions, Ann and Carol worked on combating their automatic thoughts. Carol began efforts to teach Ann about the connection between their automatic thoughts and images, intermediate thoughts, and core beliefs. Carol helped Ann chart the relationships between Ann's core beliefs, intermediate beliefs, automatic thoughts, and reactions (see the following section).

"When I came to counseling, Carol, I thought I would be able to come in here, tell you how I was feeling, and you'd give me some good ideas for how to make my life meaningful," Ann laughed. "But this is a lot more complicated than I figured! Really looking at my thoughts and how they are connected to my core beliefs and then how all that leads to how I act, well that is a lot to consider. I guess this is going to take some time and some discipline."

"You've already put a lot of work and effort into your counseling work, Ann, and you've made some important strides. I think if you continue as you have been you will reach your goals sooner than you think," Carol replied.

The Relationships Between Ann's Core Beliefs, Intermediate Beliefs, Automatic Thoughts, and Reactions

Core belief: "I am trapped, a victim, a failure, and powerless."

Intermediate beliefs attitude: "Life is unfair." Rule/expectation: "If I try to make things better, I'll just be knocked down again."

Assumption: "No matter what I do to try and change things, my life will still be unfair."

Situation: Birthday party.

Some possible automatic thoughts and images (associated with cognitive distortions):

- "Things did not turn out the way I thought they would."
- "I was cheated."
- "Why did that accident have to happen?"

- "Everyone has moved on, and I have nothing."
- Visualizing the accident
- Thinking about how Justine was before the accident
- Thinking about how Jake was before the accident

Some possible reactions:

- **Emotional:** sadness, depression, anger, regret, and hopelessness
- **Physiological:** low energy and lack of attention to health issues
- **Behavioral:** staying home, arguments with husband, and not making plans for future

For You to Consider

1. This counselor spent some time using basic attending skills to listen to Ann. How important do you think those skills are in CBT?
2. Even though some basic attending skills were used by Carol, at one point, they somewhat abruptly shifted gears to make sure that the information in the assessment was covered. Do you think this kind of shifting gears is appropriate? How else could Carol have handled this?
3. How easy do you believe it is for most clients to "catch" their automatic thoughts?
4. In this example, some possible cognitive distortions were identified that may be associated with Ann's automatic thoughts. Can you explain how those cognitive distortions feed into Ann's automatic thoughts?
5. Do you think other cognitive distortions may have also been involved in Ann's thinking processes? If yes, which ones?
6. Do you have any concerns about Ann's willingness to shift attention from the goals she had (exploring her feelings and finding meaning) to Carol's aim to look at the role of her thoughts in her unhappiness?
7. Using CBT, how might you address Ann's insight that they take their anger out on their husband? Do you think you might have suggested creating a goal from this problem? What might this goal look like?
8. Ann was eager to do the homework that Carol assigned. If you were Ann's counselor, how do you think you would work with Ann if they had chosen not to do their homework?
9. How long do you think it will take Ann to work on changing their core beliefs? Explain.
10. Given endless resources (which often is not a reality!), do you believe that once Ann understands the CBT process, they can do most of the work on their own, or would it be better for them to continue in therapy with their therapist for an extended period of time?
11. Some of Ann's concerns seemed to have an existential ring to them. How might an existential therapist work differently with Ann? Which approach would you be more apt to use with Ann? Why?
12. Can you identify any cognitive distortions, intermediate beliefs, or core beliefs of yours that you can work on? How might you go about changing them?

Summary

Born in Providence, Rhode Island, in 1921, Aaron Temkin "Tim" Beck is considered the founder of cognitive therapy. Going to medical school and struggling with some of his own fears and phobias early in life, Beck initially became a psychoanalyst. However, becoming disillusioned over the years with psychoanalysis, and finding that his clients were often aware, or could easily become aware, of "automatic thoughts," he began to develop his own theory that focused on how one's cognitive processes mediate how one acts and feels. Over the years, he has recognized his wife's role in helping him refine his theory, and in recent years, his daughter Judith Beck has become one of the leaders of cognitive therapy.

Over the years Beck found that different disorders presented with specific features related to the client's cognitive processes. Thus, Beck came up with a logical process that included hypothesizing about the cognitive processes associated with different disorders, developing manuals to assist clinicians in the treatment of various disorders, developing scales to measure the disorder (e.g., depression), and, while using the manuals, conducting clinical studies to assess the effectiveness of therapeutic interventions.

Positing a diathesis–stress model of mental disorders, CBT suggests that a combination of genetic predispositions, biological factors, and experiences combine to produce specific core beliefs, some of which may lie dormant and then suddenly appear as the result of stress and other conditions impinging on the person. CBT is seen as a rational, pragmatic, educative, empirical, structured, and antideterministic approach that proposes that people can manage and effect changes in the way they live in the world in a relatively brief amount of time. This approach has elements of a constructionist perspective when it states that through discourse with others, individuals can change their cognitions and overcome their predispositions.

Cognitive behavior therapists believe that one's core beliefs become the underlying mechanism for the creation of intermediate beliefs that set the attitudes, rules and expectations, and assumptions we live by. These attitudes, rules and expectations, and assumptions can be understood by looking at how situations in life lead to what are called automatic thoughts, which result in a set of behaviors, feelings, and physiological responses that end up reinforcing core beliefs. Beck also suggests there are a number of cognitive distortions that tend to be associated with the automatic thoughts that we have. Finally, coping or compensatory strategies, usually created early in life, are often developed by individuals to steer themselves away from experiencing their negative core beliefs. However, these strategies do not rid persons of their core beliefs, and over time, the strategies become maladaptive. Beck and other cognitive behavior therapists believe that, through a process called cognitive conceptualization, the therapist can assess the client and begin to make hypotheses about the kinds of automatic thoughts and intermediate and core beliefs that define the person. Then, strategies can be developed to help the individual change their beliefs and, ultimately, behaviors, feelings, and physiology.

Fourteen basic principles underlie the practice of CBT, and a number of essential and commonly used techniques are implemented in practice. Some of the essential techniques include building a strong therapeutic alliance, educating the client about the cognitive model, Socratic questioning, identifying and challenging automatic thoughts and images, identifying and challenging cognitive distortions, identifying intermediate beliefs, identifying and challenging core beliefs, and doing homework assignments. Some of the commonly used techniques include thought stopping, imagery changing, rational–emotional role-play, and behavioral and emotive techniques. In addition, it was noted that hundreds of other specific techniques can be used to help with the change process.

The therapeutic process can be viewed through a series of four stages: (a) intake and evaluation, which includes greeting the client and building the therapeutic alliance, discussing the purpose and process of the session and setting the agenda, conducting a mood check, conducting the assessment, developing broad initial goals, and eliciting feedback from the client; (b) the first session,

which includes conducting a mood check, setting the agenda, obtaining an update, discussing the diagnosis, educating the client about the cognitive model, identifying values and aspirations, reviewing presenting problems and setting goals, summarizing the session and developing homework assignments; providing an end of session summary; and asking for feedback; (c) the second and subsequent sessions, which includes conducting a mood check, setting the agenda, reviewing homework, shifting from automatic thoughts to intermediate and core beliefs, and asking for feedback; and (d) termination. The sessions tend to increasingly move toward client selfmanagement, as clients learn about the cognitive model and make positive changes in their lives.

Relative to social, cultural, and spiritual issues, it was noted that most of the original research on CBT has been conducted on Whites, focused little on cross-cultural issues, and offered little explanation as to how to work with diverse clients. However, in recent years some have identified ways that the approach could be more adaptable to diverse clients, and scholars have offered frameworks for culturally adapted CBT (CA-CBT). We also noted that recent CBT scholarship acknowledges the impact of societal experiences on core beliefs and the importance of linking this to symptoms, marginalization, and health care utilization when working with clients. It was also suggested that therapists examine their own automatic thoughts and core beliefs and how it might impact their work with clients. Finally, a framework for using CBT when working with marginalized clients, using the acronym ADDRESSING, was examined as well as five domains counselors should consider in their work with such clients, represented by the acronym CLASS. Relative to religious and spiritual issues, it was suggested that an assessment of whether clients view their beliefs are internal or external can dramatically change the focus of treatment.

When discussing the efficacy of CBT, it was noted that this approach has been widely researched, mostly because it has a specific mechanism for measuring the change process and because Beck has developed manuals that describe how to work with a number of disorders. A number of disorders that have shown to work well with this approach were listed. Furthermore, recent developments in CA-CBT highlight that CBT may be effective with culturally diverse clients. However, despite its apparent effectiveness with a wide variety of disorders, more focused research with culturally diverse clients' needs to be conducted. In addition, Wampold notes that when compared to other approaches, CBT, generally, is not more effective—they are all effective. This "Dodo bird effect" suggests that all methods of therapy are effective when used by competent clinicians.

Key Words and Terms

14 basic principles
acceptance and commitment therapy
active approach
adapting one's therapeutic style
ADDRESSING
all-or-nothing thinking
antideterministic
automatic images
automatic thoughts
Beck Depression Scale
behavioral and emotive techniques
behaviors
being collaborative
building a strong therapeutic alliance
catastrophizing
CLASS
cognitions
cognitive-behavioral therapy (CBT)
cognitive-behavioral approaches
cognitive conceptualization
cognitive distortions
cognitive model, the
cognitive revolution in psychology
cognitive schema
cognitive therapy
collaboration
compensatory strategies
conduct a mood check
constructionist
constructivist therapy
continuity hypothesis
coping strategies
core beliefs
culturally adapted CBT (CA-CBT)
demonstrating empathy, caring, and optimism
dialectical behavior therapy
diathesis–stress model of mental disorders

disqualifying or discounting the positive
Dodo bird effect
educating the client about the cognitive model
educative approach
eight steps for providing culturally competent counseling
emotional reasoning
empathy, caring, and optimism
empirical approach
essential techniques
genetic and evolutionary predisposition toward emotional responses
helpless core beliefs
homework
identifying and challenging automatic thoughts and images
identifying and challenging cognitive distortions
identifying and challenging core beliefs
identifying intermediate beliefs
imagery changing
intake and evaluation
intermediate beliefs
labeling
magnification/minimization
mental filter
mind reading
multimodal therapy
overgeneralization
personalization
physical sensations
pragmatic
present-focused approach
rational, pragmatic, and constructionist perspective
rational emotive behavior therapy
rational–emotional role-play
Socratic questioning
should and must statements
structured approach
termination
the first session
the second and subsequent sessions
thought stopping
time sensitive
tunnel vision
unlovable core beliefs
worthless core beliefs

Key Names

Adler, Alfred
Beck, Aaron Temkin
Beck, Beatrice
Beck, Bernard
Beck, Harry
Beck, Judith
Beck, Lizzie
Beck, Maurice
Beck, Phyllis Whitman
Busis, Deborah
Ellis, Albert
Erikson, Erik
Hayes, Steven
Horney, Karen
Lazarus, Arnold
Linehan, Marsha
Mahoney, Michael

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10 Reality Therapy

Learning Goals

At the conclusion of the chapter, readers will:

- be familiar with the life of William Glasser and the historical context in which he developed reality therapy and choice theory
- understand the relationship between one's need-strength profile and the antideterministic, present-focused, internal control, and choice-based view of human nature of reality therapy
- learn about key concepts, or the philosophical basis of choice theory, which include the 10 axioms of choice theory, needs and wants, internal control, choice, the quality world, and total behavior
- articulate how current-day reality therapy applies Wubbolding's WDEP system, which includes the **w**ants of the client (W), what the client is **d**oing in their life's **d**irection (Ds), **e**valuating if what the client is doing is working (E), and developing a **p**lan of action that can be implemented (P)
- using the WDEP system, understand the importance of exhibiting the tonics and avoiding the toxins of a counseling relationship
- identify the strengths and weaknesses of reality therapy relative to social, cultural, and spiritual issues, especially in light of the emphasis on internal control in reality therapy
- articulate the evidence regarding the efficacy of reality therapy relative to the kinds of research studies completed as well as future research directions

> ... a woman approached him [Dr. Glasser] at his home and begged him for advice for how to deal with her 3 year-old son. He paused for a long time and then reached deep down inside his soul and gave her 2 suggestions: "Always treat him as if he is good." And "Set up circumstances where he can only succeed." (Wubbolding & Wubbolding, 2013, para. 9)

Dr. *William Glasser* was a revolutionary in counseling and psychotherapy. Eschewing the idea of mental illness, he believed that pathology, for the most part, did not exist, and what individuals need in their lives is a compassionate, caring person who can teach them healthier ways of getting their needs met. Questioning many of the ideas of psychiatry and psychology, and pretty much discarding all the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), Glasser led

the charge over the years at depathologizing mental illness. Although he died quietly in 2013, his legacy lives on.

In this last chapter of cognitive-behavioral approaches, we present reality therapy. We begin by presenting the biography of William Glasser, the founder of reality therapy. We then present the view of human nature from a reality therapy perspective; its key concepts, techniques, and therapeutic processes; social, cultural, and spiritual considerations; and efficacy research on reality therapy. We conclude the chapter by illustrating reality therapy with Markus, a member of the Miller family.

William Glasser

The youngest of three children, William Glasser was born in Cleveland, Ohio, on May 11, 1925. Glasser's mother and father emigrated, separately, from politically unstable Eastern Europe in the early 1900s when they were young teenagers (Roy, 2014; Wubbolding, 2015a). Wealthy in Russia, his father's family struggled in the United States. Although not poor, when his parents eventually married, they had to work hard to make a living. Perhaps because they were not highly educated, they stressed the importance of learning, and all three children would eventually seek postsecondary educations.

FIGURE 10.1 William Glasser

Prior to the age of six, Glasser remembers his parents having violent fights and even recalls times when, in a rage, his father broke things, and one time when he hit his mother. Although frightened by the violence, he states, "Whatever difficulty they had with each other, they were always loving toward me" (Glasser, 1998, p. 89). Although the fights subsided, the animosity between his parents seemed palpable in the household. Despite his father's periodic outbursts, Glasser remembers his father as a gentle soul and his mother as controlling. In fact, in references to his father's accepting attitude toward others, Glasser states, "[Never] in the more than sixty years that I knew him did I ever see him try to control another person except when he was being goaded by my mother" (Glasser, 1998, p. 90). It is not a great leap to believe that Glasser's theory, which underscores the importance of not controlling others, was influenced by these early perceptions.

A shy child with low self-confidence, Glasser notes that *Ms. Sheehan*, a warm and loving sixth-grade teacher, encouraged him and helped him boost his self-worth (Glasser, 2003). Eventually, Glasser went on to receive his bachelor's degree in engineering from Case Western Reserve University in Ohio. After working for a year, he decided that psychology was more of a match for him, and he went back and obtained his M.S. in Clinical Psychology from Case Western. He notes that while working on his master's degree, the Dean of his college encouraged him to go into psychiatry. Despite his lack of confidence about getting into medical school, he applied and was accepted at Case Western and obtained his medical degree in 1953. As with his sixth grader teacher, Glasser points to the relationship with the Dean as having a significant positive effect on his life.

In 1953, most psychiatrists were trained in the traditional psychoanalytical approach to therapy, and this was also the case with Glasser (Roy, 2014). However, while working with patients during his residency, Glasser increasingly came to believe that his patients were struggling with basic human problems in response to which they developed symptoms, not the intrapsychic conflicts or organic deficits that many psychiatrists alleged. Taking a risk, he began to share his unconventional beliefs about psychiatry with his supervisor, *Dr. G. L. Harrington*:

> Harrington reached across the desk, extended his hand, and spoke the oft-quoted response, "Join the club." Together they began a reality-based program for the patients. After 2 years, approximately 50% of the patients were released from the hospital, with only a 3% rate of return. (Wubbolding, 2015b, pp. 856–857)

In 1957, Glasser completed his residency and went into private practice. In 1960, he wrote his first book, *Mental Health or Mental Illness,* and it is here that we see Glasser question the traditional role of psychiatry, which he had begun to question verbally during his residency (Lennon, 2000). As he expanded his practice, he also worked on developing his ideas, and in 1965, he published his first book on his theory, *Reality Therapy.* A sensation early on, this book changed the way multitudes of counselors and therapists would approach their clients. When first coming up with his theory, Glasser believed mental illness was an inability to meet two basic needs: "the need to love and be loved and the need to feel that we are worthwhile to ourselves and to others" (Glasser, 1965, p. 9).

Agreeing with *Thomas Szasz* in his classic book *The Myth of Mental Illness* (Szasz, 1961), Glasser criticized the psychiatric profession for propagating the belief that mental illness was the result of some inherently flawed biological brain functioning. Instead, he suggested that individuals labeled as mentally ill, as well as those having daily living problems, were exhibiting irresponsible behaviors because they had not formed relationships that had helped them learn how to effectively meet their needs:

> [These people] express their unhappiness in the symptoms described in the DSM-IV plus many others like pain and anger. For them to become more mentally healthy and happier, we have to offer compassion, social support, education, and counseling. They do not need brain drugs and electric shocks, all of which harm their brains. (Glasser, 2003, p. xxii)

While in private practice, Glasser became gradually more involved with applying his theory in educational settings (Glasser, 2006; Roy, 2014). In 1956, Glasser consulted with the Ventura School for Girls, a correctional facility for girls between the ages of 15 and 19. There he was able to convince the staff to apply his theory, which increasingly focused on building trust and respect, the use of discipline (e.g., having consequences for not following through on the change process), the elimination of punishment (not imposing pain following a behavior a person in power doesn't like), highlighting successes, and helping the girls make good choices that would better meet their needs. As his reputation spread, he was offered a substantial amount of grant money by the W. Clement Stone Foundation of Chicago to develop and implement his ideas. This money was critical to the establishment, in 1967, of the Institute for Reality Therapy and Educator Training Center. Then, in 1969, while still consulting with the Ventura School, Glasser published his revolutionary book, *Schools without Failure*, which highlighted how his ideas could be used in educational settings (Roy, 2014). Quickly, schools around the country adapted his methods of working with children. Although changed over the years, Glasser's positive approach to working with children continues to be used in schools worldwide (Glasser, 2006).

During the 1970s, Glasser continued to write books that expanded some of his core ideas, such as the book *The Identity Society* (1972), which elaborated on some of the practical techniques of reality therapy, and *Positive Addiction* (1976), which highlighted the importance of choosing important positive behaviors in one's life. During this decade, Glasser also became intrigued by *William T. Powers's perceptual control theory*, which looked at how perceptions influence the way we control our environment in an effort to get our needs met (Powers, 1973). Adapting many of Powers's ideas, Glasser developed his own version of *control theory* that became the underlying principles to the practice of reality therapy. Some of Glasser's books that reflected these changes included *Stations of the Mind* (1981), *Control Theory* (1984), *Control Theory in the Classroom* (1986), and *Control Theory in the Practice of Reality* (1989).

During the 1990s, intrigued by *Edward Deming's total quality management (TQM)* approach, which applied humanistic and systems principles to business and industry (Deming, 1986), Glasser again adapted his theory by highlighting the importance of clients making choices that would enable them to live in a world that matched their internal image of what the world should look like. Calling this the *quality world*, Glasser suggested that clients could best make positive choices that matched their quality worlds if they were afforded a supportive environment free of coercion and criticism. At this point, Glasser changed the name of his institute to the *Institute for Reality Therapy, Control Theory, and Total Management* (Roy, 2014).

Although Glasser incorporated many of Powers's ideas into his theory, he also differed with some of his ideas, such as the use of the word "control." Thus, in 1996, Glasser decided to use the name *choice theory* (Glasser Institute for Choice Theory, n.d.; Roy, 2014). His books *Choice Theory* (1998) and *Counseling with Choice Theory* (2001) reflect these changes. Soon, Glasser again changed the name of his institute, this time to the *William Glasser Institute*, highlighting the fact that reality therapy and choice theory were based on his ideas. Today, the successful application of reality therapy (the process) is dependent on a thorough knowledge of choice theory (the theory; William Glasser Institute, n.d.a; Wubbolding, 2015b). Reality therapy is often described as the train, while choice therapy is the tracks—with the two being inextricably related.

As Glasser learned from others, he adapted his theory. For instance, his original theory had humans possessing two basic needs, but later, this grew to five. His ideas that individuals should take responsibility for their behaviors and face their unique "reality" morphed into a theory wherein individuals examine their needs and their quality worlds and develop *internal control language*, so they can more efficiently direct their lives (Glasser & Glasser, 2000; Van Nuys, 2007). Glasser eventually came to believe that we all make the best choices we know how to make as we attempt to meet the pictures in our quality worlds, and almost all of us could make better choices if placed in an environment that could teach us how to do so (Glasser, 1998, 2001; Glasser & Glasser, 1999).

Over the years, as Glasser's ideas and reputation spread, he became one of the leaders in counseling and psychotherapy (William Glasser Institute, n.d.b). Known worldwide, his books were translated into several languages, and he received many notable awards, including *ACA's A Legend in Counseling Award*; the esteemed designation of *Master Therapist by the American Psychotherapy Association*; and the *Life Achievement Award by the International Center for the Study of Psychiatry and Psychology*. On August 23, 2013, Dr. William Glasser died peacefully in his home, surrounded by his wife Carleen and his son Martin.

Over the years, two important women helped him sort through his ideas and assisted him in writing and editing some of his books. His first wife, *Naomi Glasser*, was by his side until her death in 1992. Later, his second wife, *Carleen Glasser*, assisted him as he has continued to refine his ideas and cowrote with him *Eight Lessons for a Happier Marriage* (Glasser & Glasser, 2007). In addition, numerous associates have helped train over 100,000 individuals in reality therapy, in applying the theory to educational and organization consultation, and in clarification and expansion of the theory (William Glasser International, n.d.a). *Bob Wubbolding*, one of the first to be trained in reality therapy at the Institute, has been particularly noteworthy, especially in his adaptation and expansion of the theory (Zalaquett & Wubbolding, 2016) (see Box 10.1).

BOX 10.1 Want to Meet William Glasser?

Want to hear a brief biography about Glasser from the man himself and find other tidbits of information about him? Go to https://silver.odu.edu/psyadm/ to see a caricature of Glasser talking about himself and his theory. Click on the cognitive-behavioral door and go into Glasser's office.

View of Human Nature

> I'm trying to persuade the counselors, he explained, to move away from mental illness and drugs, to mental health and happiness. That's where I am. I believe there is such a thing as mental health. (Glasser, 2004, as cited by Roy, 2014, p. 375)

Reality therapy posits that we have five genetically based needs, the original of which is the *survival* need that helped us endure thousands of years ago in a difficult world. From the survival need spun off the needs for *love and belonging*, *power*, *freedom*, and *fun* (to be discussed later in more detail). The strength of all five needs is said by Glasser to be "fixed at birth and does not change" (Glasser, 1998, p. 91). The way individuals learn to meet their unique *need-strength profile* is said to reflect our personality.

Glasser (1998, 2001) suggested that from the moment we are born, we begin to create our *quality worlds*, which contain the unique pictures in our minds of the people, things, ideas, and beliefs most important to us in meeting our unique need-strength profiles (Lujan, 2015; Wubbolding, 2012). As some examples, these pictures might include the life partner we want, the car we want to buy, and a religious belief to which we want to adhere. But they also might include alcohol or drugs we desire and possibly abuse, or an image of us controlling others, as the quality world does not have a moral base—it simply provides us pictures of what we want. If the individual can choose behaviors that match the pictures in their quality world, that person will satisfy one or more of the five needs and feel content, at least for a short period of time. However, some choices (e.g., substance abuse) can and do have negative long-term consequences, even though they might temporarily meet one's needs. The pictures in our quality world change throughout one's lifetime (Wubbolding, 2015b), and pictures that previously satisfied us can remain in our minds for long periods of time and can sometimes become a source of pain if we cannot satisfy them. For instance, it can take a long time to rid oneself of the image of a lover who has left.

Central to reality therapy is the idea that our *total behavior*, which includes our actions, our thinking process, our feelings, and our physiological responses, is the result of our efforts to satisfy the pictures in our quality worlds. Glasser goes on to state that we can only choose our actions and thoughts, which are jointly called *doing*, and that our feelings and our physiology result from those choices. Keep in mind, however, that feelings and physiology can be motivating in the sense that they can affect the kinds of actions and thoughts made; thus, the four elements are considered inseparable.

Glasser suggests that the language a person uses is reflective of how that person makes choices in an attempt to meet their needs (Glasser & Glasser, 1999). *Internal control language* is accepting, respectful, and supportive of others and reflects a person who is clear about the choices that will best meet their needs. Contrast this with *external control language*, which is blaming, critical, and threatening of others and reflects a person who has not learned how to make choices that best meet their needs. These individuals tend to see their lives as controlled by others and by events. However, because external control is all that they know, they have "chosen" the best they can. Those who come to counseling are often struggling with language and behaviors that reflect external control, which was generally adopted from the environment to which they were exposed as they grew up (Wubbolding, 2000; see Box 10.2). Therefore, one role of the counselor is to provide an atmosphere conducive to teaching about internal control and choice and to help clients broaden the behaviors they generate in an effort to satisfy the pictures in their quality worlds.

BOX 10.2 Interview With a Hit Man

Here is a portion of an interview between a mob hit man, Richard Kuklinski, and psychiatrist, Dr. Dietz, in which we see Dr. Dietz responding to Mr. Kuklinski's question regarding why he viciously murdered over 200 people. Similar to how a helper who practices reality therapy might respond, the psychiatrist suggests that Mr. Kuklinski's personality was not destined but developed as a result of the parenting style he received.

> But the fact that you're born with a genetic predisposition toward fearlessness doesn't mean that it's inevitable for you to become a criminal, because some people who have the genetic predisposition toward fearlessness become pro-social risk takers. They do things like drive racecars, test-fly planes, [become] fighter pilots, bomb disposal technicians. Those are all jobs where it helps to have a lot of fearlessness and in fact, some people in law enforcement are brave and have that same capacity to be fearless. ... If you raise a kid with love and kindness and affection most of the time you have got a good shot at their growing up to be a decent, caring, loving human being and treating their own kids well. But if you raise a kid the way Stanley [Kuklinski's father] raised you, with no love, no affection, constant abuse, beatings for no reason, all you teach is hatred. (Heller et al., 2003)

Since language reflects how a person makes choices, Glasser has long advocated that clients, and others, use language that clearly reflects that we choose our behaviors. For instance, instead of saying something like, "My depression is making me sleep all the time," "I have a mental illness that has stopped me from working," or "My anger makes my blood pressure go up," Glasser suggests that individuals say such things as, "I am depressing myself and choosing to sleep much of the time," "I choose behaviors that make me seem mentally ill and then choose not to work," and "I anger myself and make my blood pressure rise." The use of language that clearly shows that a person is responsible for their state in life conflicts with the contemporary view held by many in mainstream psychiatry, which suggests that mental disorders are the result of some intrinsic, organically based problem (e.g., genetic differences in brain function) or that individuals are determined by such things as early childhood experiences.

As you can probably tell, Glasser's approach is *anti-deterministic* because at any point in life, a person can evaluate their total behaviors and learn how to make new choices that better match one's quality world and need-strength profile. And because Glasser believed that needs can only be satisfied in the *here and now*, the approach is focused mostly on the present. Even if an individual had been traumatized and learned maladaptive ways of behaving in an attempt to meet their needs, that person can learn new ways of choosing that can lead to more effective satisfaction of needs. Generally, people can learn new ways of choosing through the development of relationships that are accepting, loving, and caring, such as one might find in therapy. Such relationships teach individuals which behaviors will match their quality worlds in healthy ways and the importance of using internal control language.

As you read this view of human nature, you may be wondering why this approach is in the cognitive-behavioral section of the text and not the existential–humanistic section. Undoubtedly, this approach has a cognitive bent, as it focuses on people's perceptions of their quality worlds. It also has a strong behavioral focus, as it spends much time on finding new behaviors that are better at meeting needs in one's quality world. However, it clearly has an existential orientation with its focus on the present and its emphasis on choice. So you can see how it is somewhat arbitrarily

placed in this section, and if you think this approach fits better elsewhere, you could have a strong argument for moving it. For now, we'll keep it here.

Key Concepts

Choice theory is the philosophical basis of how we come to understand the person, while reality therapy is how the counselor applies their skills to impact the client based on that philosophical understanding (Glasser, 2001; William Glasser Institute, n.d.c; Wubbolding, 2020). Thus, the key concepts in this section help us understand the basis of choice theory, while the next section, on techniques, will examine how counselors help the person change. Here, we will review the *10 axioms of choice theory*, *needs and wants*, *internal control*, *choice*, *the quality world*, and *total behavior.*

The 10 Axioms of Choice Theory

The *10 axioms of choice theory* help us understand the basis of choice theory and begins to offer us a sense of how it is applied. They include the following:

1. The only person whose behavior you can control is our own.
2. All we can give or get from other people is information.
3. All long-lasting psychological problems are relationship problems.
4. The problem relationship is always part of our present lives.
5. What happened in the past that was painful has a great deal to do with what we are today, but revisiting this painful past can contribute little or nothing to what we need to do now: improve an important, present relationship.
6. We are driven by five genetic needs: survival, love and belonging, power, freedom, and fun.
7. We can satisfy these needs only by satisfying a picture or pictures in our Quality Worlds.
8. All we can do from birth to death is behave. All behavior is Total Behavior and is made up of four inseparable components: acting, thinking, feeling and physiology.
9. All Total Behavior is designated by verbs, usually infinitives and gerunds, and named by the component that is most recognizable.
10. All Total Behavior is chosen, but we have direct control over only the acting and thinking components.

William Glasser, "The Ten Axioms of Choice Theory," *Choice Theory: A New Psychology of Personal Freedom*. Copyright © 1999 by HarperCollins Publishers.

Needs and Wants

Individuals' wants are unique and are based on the need-strength profile as reflected in one's quality world. So, "I want this" or I want that" is the individual's attempt to get their needs met. It is important to assess whether one's *wants* are adequately meeting one's *needs*, for sometimes, the way we get our needs met can be destructive (e.g., using substances for our need for love and belonging; Ellsworth, 2007).

Glasser identified five needs as critical to human functioning, including *survival*, *love and belonging*, *power*, *freedom*, and *fun* (Glasser, 2001; Wubbolding, 2015b) and suggested that each individual

has a specific need-strength profile that is based on their genetics. The kinds of choices we make to meet our needs defines our personality. Needs can conflict with one another. For instance, a need to feel a sense of love and belonging with one's family may conflict with a need for power that one fulfills through writing; thus, one might feel conflicted about whether to work (write) or spend time with family. Which needs we satisfy are basic to the kinds of choices we make from moment to moment, help define who we are, and are important to whether we feel content. As you read about the needs, consider *your* specific need-strength profile, how you go about meeting your needs, and which needs of yours compete with one another.

- **survival (or self-preservation):** Survival is basic to our existence and includes survival of the species through sex and self-preservation by ensuring we have food, shelter, safety, and health. To live in a civilized world, the mechanisms we formerly used to survive (e.g., aggression, hunting without regard for species extinction, becoming an "alpha" male or female, and stealing) have had to be managed to ensure mutual survival. Thus, today's need for survival may be more related to one's drive to make a living and the desire to find a partner. Glasser (1998) also suggested that the other four needs separated from the survival need because they increased the likelihood of survival. Thus, those who can successfully love and belong, be powerful, enjoy freedom, and have fun are more likely to survive.
- **love and belonging:** As humans evolved, building relationships with one another to ensure we could mutually survive, and even thrive, became ever more important. Today, in wealthier countries, the survival needs of most individuals are mostly met. However, the need for love and belonging is often the one need with which people struggle the most. And if this need is not fulfilled, it is difficult to fulfill the other three needs of power, freedom, and fun because these needs generally involve relationships. Thus, one major focus of reality therapy is to help clients examine how they are fulfilling their relationship needs.
- **power (or inner control):** Wubbolding and Brickell (2015) suggest that power is like the French word *pouvoir*, which means "to be able; to be capable" and is related to having "a sense of empowerment, worthiness, self-efficacy, self-value, recognition, and achievement" (p. 14). Power is felt by the person who attempts to beat their personal record, by the individual who competes with others, and by the person who strives to discover something new or accomplish a difficult personal goal. Power has been the motivating force for exploring the solar system and for the invention of a multitude of products that have led to the betterment of all societies. On the other hand, power is easily abused, such as in the case of the autocratic leader who commits genocide, the corrupt Wall Street broker who uses illegal means to attain money, and the teacher who takes pride in failing their students to "show them" the results of not "properly" achieving. Power can be life-sustaining and creative and can help us feel good about ourselves, or it can be destructive and life-threatening.
- **freedom (or independence):** Freedom is the ability to do what we want, when we want, as long as it does not cause harm to others (e.g., one is not free to yell "fire" in a crowded movie theater, go through red lights, or not vaccinate their children). Freedom allows individuals to be creative, inventive, and expressive, and people who allow themselves personal freedom are rarely selfish and generally share their creativity easily and readily with others. Many see freedom as a basic human right, as reflected in a democracy. Personal freedom reminds us that we freely choose all our behaviors and are ultimately the makers of our own destiny. Glasser (1998) suggested that the enemy of freedom is the attempt to control others and that true freedom follows the *Golden Rule*, whose universality can be found in many cultures and religions (see Table 10.1).

TABLE 10.1. The Golden Rule

Religion	Source	Statement
Baha'I faith	*Epistle to the Son of the Wolf* by Bahá'u'lláh	He should not wish for others what he does not wish for himself
Buddhism	Urdana-Varga 5:18	Hurt not others in ways that you yourself would find hurtful
Christianity	Matthew 7:12	Do unto others as you would have others do unto you.
Confucianism	Doctrine of the Mean 13.3	One word that can serve as a principle of conduct for life [is] reciprocity. Do not impose on others what you yourself do not desire.
Hinduism	The Mahabharata 5:1517	This is the sum of duty: do naught to others which would cause pain if done to you.
Islam	The Hadith	"Do unto all men as you would wish to have done unto you; and reject for others what you would reject for yourself."
Jainism	Acarangasutra 5.101–2	Therefore, neither does he cause violence to others nor does he make others do so.
Judaism	Hillel the Elder; The Talmud	What is hateful to you, do not to your neighbor. This is the whole Torah, all the rest is commentary.
Zoroastrianism	Shayast-na-Shayast 12:29	Whatever is disagreeable to yourself do not do unto others.

Note. Adapted from *New world encyclopedia*, 2020. The golden rule. https://www.newworldencyclopedia.org/entry/Golden_Rule#Buddhism

- **fun (or enjoyment):** Stating that "fun is best defined by laughter" (Glasser, 1998, p. 41), Glasser also believed that fun is a learning process. Our innate ability to laugh and have fun is seen in the infant, as they laugh at a smiley face or at a new task not before undertaken. Adults have fun, especially when they love, as they allow one another to try new ways of being with one another and experiment together with new activities in the world. Lack of fun, suggested Glasser, is a symbol of a relationship's souring.

  Fun can be obtained in countless ways. It is experienced when we read something interesting and novel or when we feel a sense of satisfaction as we slowly master a new sport and later experience the joy of playing it. It is felt in the laughter we experience over a new amusement park ride or when we make sense of a joke. And fun is apparent when we feel a sense of curious joy as we discover how a new electronic device works and take pleasure in its use. We continually experience the fun and joy when uncovering new ideas, learning new tasks, or discovering new things about other people, and our lives would be stagnant if this were not the case.

Internal Control

From the moment we are born, choice theory asserts that how we feel reflects the behaviors we choose in our attempts to satisfy our needs (Glasser, 2001). Unfortunately, many erroneously believe that external factors determine behaviors and are responsible for how one feels (Glasser, 2013). These individuals believe that when the doorbell rings, it is the ringing that causes them to answer the door—not the fact that the ringing is providing them information to which they can respond. These individuals blame their negative feelings on such things as a "mental disorder" or

the result of someone treating them badly. "If only I was not depressed," or "If only she would act differently," or "If only my parents were nicer" are the mantras these individuals live by.

People who live by an *external control* philosophy tend to blame, criticize, bribe, complain, punish, torture, are passive-aggressive, or in other ways try to manipulate others in an attempt to change the external factors they believe cause their unhappiness. However, such attempts at controlling friends, colleagues, lovers, and others result in relationships marked by control issues and power disparities and relationships that lack the caring that can come from allowing a person to be themself (see Box 10.3; Glasser & Glasser, 2007; Van Nuys, 2007).

BOX 10.3 External Control and the Abusive Spouse

Abusive husbands have erroneously learned, generally from their abusive parents, that external factors are the cause of a person's happiness in life. As their parents unsuccessfully attempted to live more satisfying lives by controlling each other and their children, they unknowingly and mistakenly taught their children to believe that controlling others would lead to a more satisfying life. So when their children grow and eventually marry, a cycle of abuse begins wherein the spouse continually emotionally and physically abuses their spouse in an attempt to get their spouse to fulfill their needs … in accord to the abusing partner's wishes. However, this leaves the spouse feeling resentful toward and extremely unlikely to want to build a relationship. Such resentment, of course, prevents a sense of love and belonging, and this important need is not fully met through the relationship. In contrast, consider the couple that allows each other to make choices about what each of them wants. Although each person's immediate needs will not always be satisfied by the other, in the long run, partners will feel more loving toward each other, as they recognize the freedom they have been given.

In contrast, those who live with a sense of *internal control* thoughtfully and actively choose their behaviors and consider how their choices will affect fulfillment of their needs and how their actions will affect others. The language they use is reflective of this internal orientation. For instance, instead of saying, "I can't," these individuals say, "I won't." Or instead of saying, "I'm too depressed to go out," these people say, "I am depressing myself and choosing not to go out." Or instead of saying, "He makes me crazy," these people say, "I make myself crazy whenever I'm around him." Learning to identify the language of external control and changing one's language to reflect internal control and choice is one of the goals of counseling using choice theory (Glasser, 2001; Glasser & Glasser, 1999; Wubbolding, 2012).

> [I]f our behaviors are chosen, it is inaccurate to describe them by using nouns and adjectives. To be accurate, verbs are the only part of speech that should be used to describe behavior. For example, the commonly used terms *depression* (a noun) or *depressed* (an adjective) are inaccurate. Following choice theory, we would use the verb forms *depressing* (a gerund) or choosing *to depress* (an infinitive). (Glasser, 2001, p. 25)

Those who live by a philosophy of internal control take responsibility for their behaviors, don't blame others, are helpful to others, can place themselves second to others, and exhibit behaviors that are incompatible with the use of coercion. To encourage internal control behaviors and healthy relationships, Glasser (2007) and Van Nuys (2007) suggest that clients work on exhibiting *seven caring habits*, while avoiding the *seven deadly habits* (see Box 10.4). Relationships anchored in caring habits allow for differences, are negotiable, and are loving.

BOX 10.4 Seven Caring Habits and Seven Deadly Habits

Caring habits	Deadly habits
supporting	criticizing
encouraging	blaming
listening	complaining
accepting	nagging
trusting	threatening
respecting	punishing
negotiating differences	bribing

Choice

> All we do from birth to death is behave, and every behavior is chosen. (Glasser & Glasser, 2000, p. 24)

Basic to choice theory is the idea that one is constantly making *choices*, for the purpose of need satisfaction, that can lead to healthy or dysfunctional ways of living in the world (Wubbolding, 2015c). Those who use the behaviors and language of external control will generally develop dysfunctional relationships, as they fail to take responsibility for their actions and blame and criticize others (Glasser, 2013). Although making the best choices they know how to make, these individuals choose poorly, usually because they had significant people in their lives who modeled external control, and they have subsequently grown to believe that one's fate is not in one's hands. Such individuals end up depressing themselves, stressing themselves, angering themselves, making themselves neurotic or psychotic, and so forth, all the while believing it is not their doing.

BOX 10.5 Can the Hit Man Change?

Go back and reread Box. 10.2. Do you think a person like Mr. Kuklinski would ever have the ability to change? Can a person like Mr. Kuklinski adopt a new internal control language? Can he make new choices? Can he find new and more ways of getting his needs met and of acting and relating? If you think he can, you are a prime candidate to be a reality therapist.

Since reality therapy is antideterministic and forward-looking, counselors who practice this approach believe individuals can quickly learn that they have been choosing behaviors built on the fallacious belief that external control works. And they also know that once the language of internal control is learned, clients can begin to make more effective choices. At any point in one's life, reality therapy maintains that one can choose to build new relationships anchored in internal control and based on respect and caring (see the seven caring habits in Box 10.4). Such relationships have the ingredients for individuals to make positive choices in their lives—choices that bring need satisfaction in healthy ways (see Box 10.5).

Quality World

From birth, each of us has a model or picture of the kind of world that would most satisfy our needs (Glasser, 2013). Called our *quality worlds*, these pictures reflect what is important to us and what we most desire or want, including "(1) the *people* we most want to be with, (2) the *things* we most

want to own or experience, and (3) the *ideas or systems* of belief that govern much of our behavior" (Glasser, 1998, p. 45).

> All day long our minds drift back and forth to the images in our quality worlds; we can't get them off our minds. Examples of these pictures are the new homes we are saving for; the new jobs we want so much; the good grades that are so important to our future; the men and women we plan to marry; and our sick children, who are recovering their health. For alcoholics, the image is the alcohol they crave so much; for gamblers, the run at the crap table that is always on their minds; for revolutionaries, a new political system to replace the one they hate so much, and for religious people, the picture of heaven or paradise in which they hope to spend eternity. (Glasser, 1998, p. 45)

The people, things, and ideas that have emerged in our quality worlds are based on our unique need-strength profiles and the ways in which we have been taught to meet our needs. There is no moral base to the quality world; it simply wants what it wants. If we have learned how to make choices using an internal control philosophy, our language will reflect the seven caring habits, and we will make smart choices that directly meet our needs. However, if we have learned to make choices based on external control philosophy, our choices will be mired in control issues because we see our lives as being directed by outside forces. These individuals will try to manipulate these outside forces (e.g., a lover, a colleague) in an effort to get their needs met. These choices do not bode well for relationships or long-term satisfaction of needs.

Changing pictures in one's quality world is not easy because they are based on our limited knowledge of the world and generally represent the only way individuals have learned to meet their needs (Glasser, 2013). However, in contrast to our genetically based need-strength profile, pictures are not an inherent aspect of who we are, and with effort and new knowledge, old pictures can be discarded, and new ones can be established to meet the same needs the old pictures had served. For instance, a person who has not learned how to develop loving relationships may become addicted to drugs, using drugs to fill a void they experience in their lives. This creates a false sense of "love" in their life. This person needs to discard the picture of the drug currently in their quality world, learn how to develop relationships that will bring them a sense of love and belonging, and develop new pictures that will reflect this new way of being in the world. In addition, sometimes, pictures that were placed in one's quality world become obsolete and no longer serve a need-satisfying function. Pictures in one's quality world can become painful. For instance, the picture of my (Neukrug's) mom making me dinner, which used to motivate me to be with her and be a mechanism for partly satisfying my need for love and belonging, remains in my quality world, despite the fact that she is no longer alive. Now that picture just brings me sadness. Unless I modify or remove this picture, I will feel depressed because I can no longer choose behaviors to make this happen. Can you think of things I can do to modify or remove this picture? Understanding the quality world of the client is critical to helping the client find ways of most effectively meeting their needs and to help the client discover those pictures that may no longer be serving a need-satisfying purpose.

Total Behavior

When counselors who use reality therapy use the word "behavior," they are almost always referring to what they call *total behavior*, which is composed of four elements: *acting*, *thinking*, *feeling*, and *physiology* (Glasser, 1998, 2001). However, choice theory maintains that we can only choose how we act and think (which they call *doing*) with feelings and physiological responses being viewed as a product to how one acts and thinks (Wubbolding, 2015c). Reality therapists often use the image of a car with front wheel drive to describe this process. The front wheels represent our acting and thinking—those aspects of the car that one can control, whereas the back wheels (our feelings and

physiological responses) are more of a response to how we act and think. Our acting and thinking is based on our wants, which are, in turn, based on our unique need-strength profile (our *basic needs*). The individual is in the driver's seat, using their thoughts and behaviors to get their wants met (see Figure 10.2). And how one does that will impact how one feels and one's physiological responses.

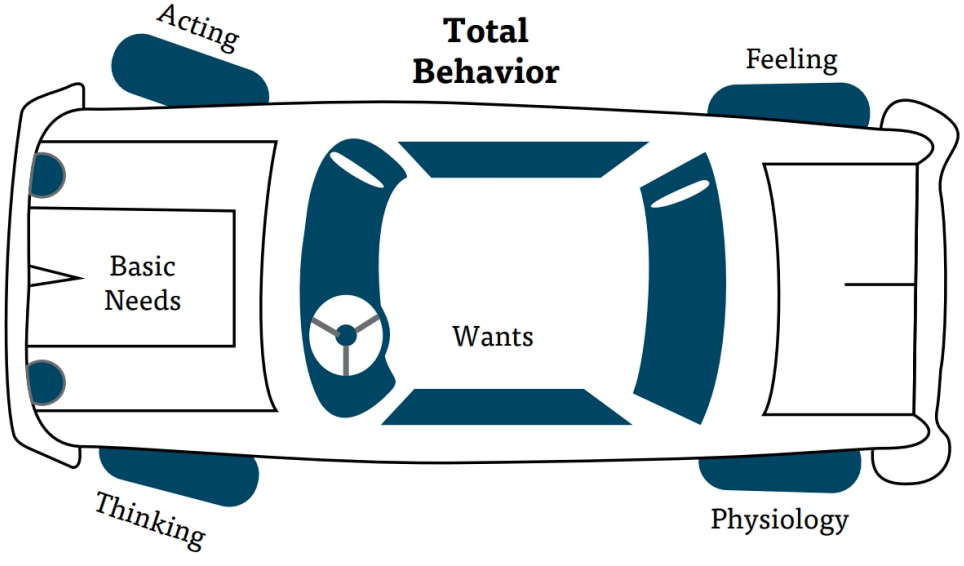

FIGURE 10.2 Our Total Behavior

Although one cannot actively choose feelings and physiological responses, there is an intimate relationship between our actions, thoughts, feelings, and physiological responses (see Box 10.6). Certainly, this makes some intuitive sense. If a person is depressed and lethargic and then suddenly decides to start going to an exercise class, they are doing something different. Their actions have changed, what they think about will be different, their feelings will likely be affected in a positive way, and as their blood pumps rapidly through their system, their physiology will be affected on multiple levels. Thus, in counseling, if we want to change how we feel, and if we want to affect our physiology, we must do something different—which entails making new and better choices about how we act and think.

BOX 10.6 The Inseparability of Our Actions, Thoughts, Feelings, and Physiology

Consider the possible interconnections between actions, thoughts, feelings, and physiology for a depressed person. For instance, what might be some typical behaviors of a person who is depressed? What kinds of "self-talk" might that person have? What kind of feelings will that person tend to have? Discuss the possible implications that acting, thinking, and feeling in those ways will have on a depressed person's physiology. Be as specific as possible. When you have finished, discuss the other people listed:

- A person with a thought disorder (e.g., "diagnosed" with schizophrenia)
- A person who is "bipolar"
- A person who is a compulsive liar
- A content person
- A person who is competitive at work and has little concern for how they outdo others

The Relationships Between Key Concepts of Choice Theory

As you can tell by Glasser's 10 axioms as well as your reading, the key concepts of choice theory are interrelated. Figure 10.3 offers a visual representation of many of these concepts and graphically shows how they fit together.

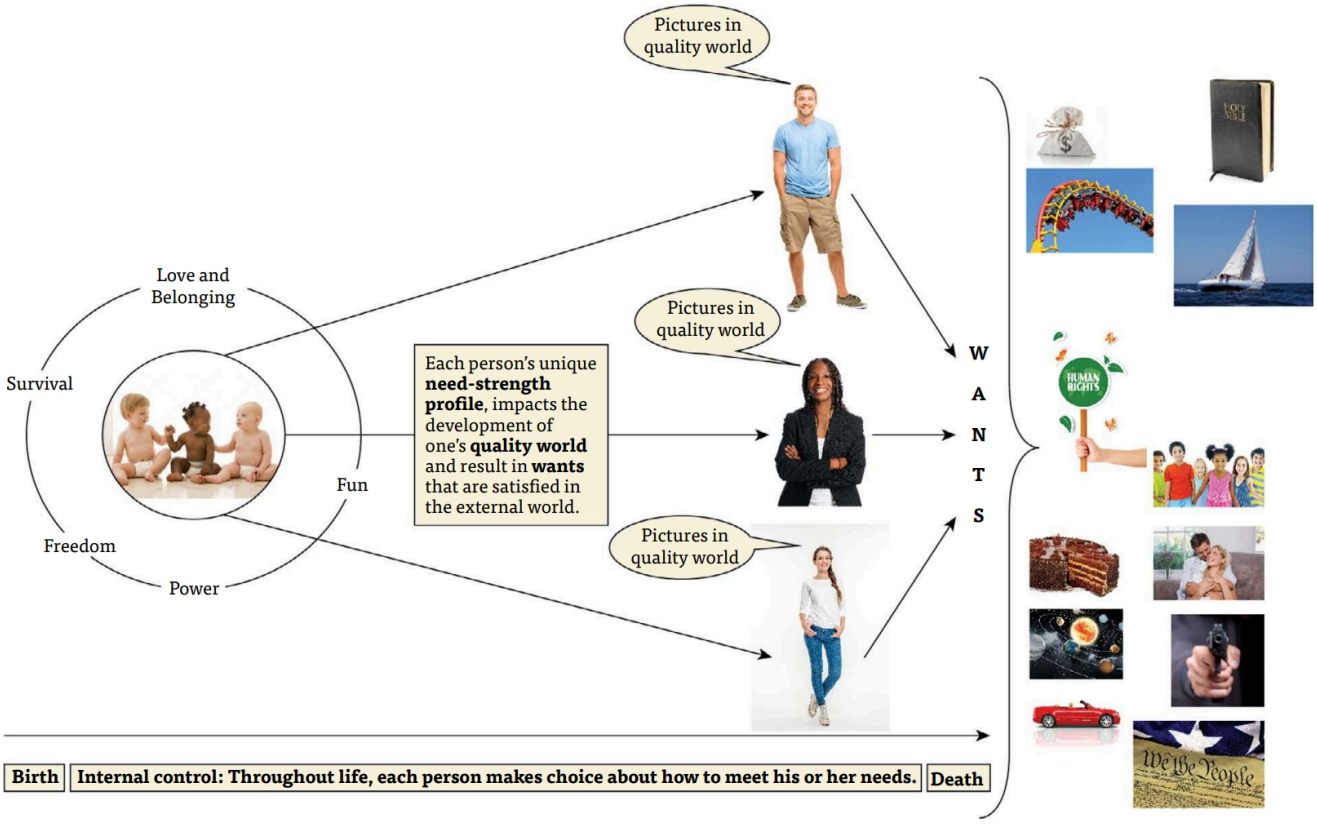

FIGURE 10.3 Relationships Between Internal Control, Needs, Quality World, Wants, Choices, Total Behaviors

Therapeutic Techniques

Today, a common method of training reality therapists is the *WDEP system*, developed by Bob Wubbolding (2015b, 2015c, 2019a). This system stands for wants of the client, what the client is doing in their life's direction, evaluating if what the client is doing is working, and developing a plan of action that can be implemented. When using this system, Wubbolding highlights the importance of embracing and practicing the *tonics of the helping relationship*, which are those attitudes and techniques that will facilitate a strong therapeutic relationship, while avoiding the *toxins of the helping relationship*, which are those attitudes that are destructive to the relationship (see Figure 10.4). The next section on therapeutic process describes the actual WDEP cycle. The tonics of the helping relationship described here, along with a fair number of questions that will be described in the section on therapeutic process, jointly make up the techniques used by many reality therapists.

Tonics of the Helping Relationship

The tonics of the relationship, listed in Figure 10.4, represent a series of techniques and relationship skills that can positively impact the counseling relationship. Let's take a quick look at each of these:

- **Structure the relationship:** Make sure clients know the basics of what is entailed in a good and ethical counseling relationship and offer a good sense of where the counseling relationship is heading. Often, using a professional disclosure statement and obtaining informed consent will help with this important aspect of the helping relationship.
- **Use attending behaviors:** Be aware of basic nonverbal skills, like eye contact, posture, and using your listening skills effectively.
- **AB:** Always be consistent, courteous, calm, enthusiastic and determined that there will be positive improvement.
- **Suspend judgment:** Convey an accepting and nonjudgmental attitude, so clients will feel free to discuss their deeper thoughts and feelings and be more likely to better understand the kinds of debilitating choices they have made. Although counselors should be able to share thoughts with their clients about how their clients' behaviors may not be healthy (e.g., a substance abuser or a person with anger management issues), they should do this within a nonjudgmental framework (Wubbolding & Brickell, 2015).

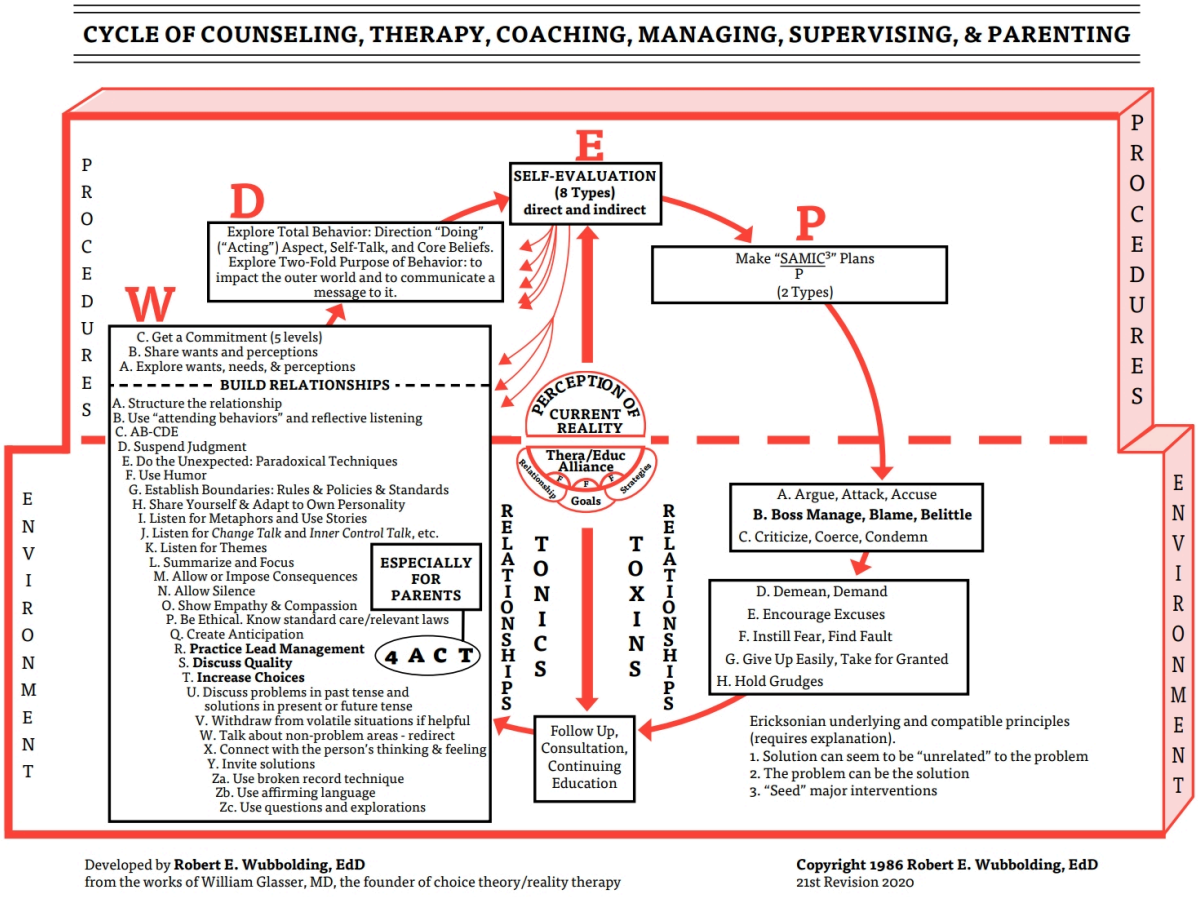

FIGURE 10.4 Cycle of Counseling, Therapy, Coaching, Managing, Supervising, and Parenting

- **Do the unexpected:** Doing the unexpected can motivate clients. So for the depressed client, a counselor suddenly might say, "Tell me the time you last laughed out loud." After the client's response, the client is asked to see if they can make that happen again. Another counselor might suddenly ask a client with agoraphobia to go for a walk with the counselor on a busy street. Sometimes associated with the technique of paradoxical intention (prescribing the symptom to induce change), doing the unexpected can have unexpected positive responses.
- **Use humor:** Humor can go far in building a relationship and motivating a client to work on change as long as it not satirical or mean (Wubbolding & Brickell, 2015). Clearly a technique that should be used carefully (e.g., one does not use humor when a client is discussing the death of a loved one), humor is a skill that counselors can use to their advantage.
- **Establish boundaries:** Letting clients know about the boundaries of the counseling relationship (time limits of sessions, any limits to calling the counselor during the day, etc.) helps define the boundaries of the relationship as clients work toward change.
- **Share self:** Although certain aspects of a counselor's life are clearly off limits, there are times when counselor self-disclosure can strengthen the relationship (Glasser, 1961). For instance, if a client is a sports enthusiast, and so is the counselor, talking about a particular sport might help strengthen the relationship. Self-disclosure can also involve giving honest feedback to the client. For instance, the reality therapist might say to the addict: "Clearly, shooting heroin is not good for you. This behavior is not getting you what you want." Or, paraphrasing Glasser, "It is congruent with the principles of reality therapy for someone to tell the blind person that they cannot become an airline pilot" (Wubbolding, 2000, p. 148).
- **Listen for metaphors:** A client's quality world is often represented by the metaphors and stories told to the counselor. For instance, a counselor might discuss a client's unmet love and belonging needs after the client states, "I keep trying to work on my marriage, but I feel like I'm a turtle in its shell, afraid to come out."
- **Listen for change talk and inner control talk:** As clients begin to realize that their wants in their quality world are not being met in healthy ways, they will begin to use language that indicates they are ready to change. It is important to reinforce such change and to encourage clients to begin to take action toward new behaviors that will meet their wants and satisfy their needs in healthy ways.
- **Listen for themes:** Hearing themes from a client can help the counselor offer insight into the client's world. For instance, when a client says, "My kids only want me to help them with their homework," "My wife just sees me as a person to fix things around the house," and "Even fishing is boring these days," the counselor might say to the client: "It sounds like you're not having fun in life and don't feel loved."
- **Summarize and focus:** Summarizing and focusing all of what the client has told the counselor can help clients see the kinds of needs and wants that are not being fulfilled and can also help to reinforce new choices clients have made or will make. For instance, a counselor might say, "As I listen to you today, I hear the control and power issues you're having in many of your relationships." Or another counselor might say, "You know, you have really worked hard, and I hear what progress you have made toward building solid relationships in your life."
- **Allow or impose consequences:** Allowing a client to experience consequences of behaviors can raise consciousness about how destructive certain behaviors have been. For instance, a client's lover may be enabling the client's drinking by hiding alcohol and making excuses for the client who is consistently late to work. Having the client experience the consequences of their behavior (e.g., hitting bottom) can "push" the client toward working on the problem behaviors. Allowing or imposing consequences is often used in institutional settings (e.g., schools) to help students understand how their behaviors can be destructive.

- **Allow silence:** Silence is golden, as it allows clients to hear themselves, reflect on what they are saying, and consider the consequences of their behaviors. Finally, it allows clients to think about new ways of acting.
- **Show empathy:** Empathy is hearing the client fully, understanding unexpressed feelings, and seeing the complexity of themes related to what the client is saying. Using empathy can help clients understand their needs and wants before they develop new ways of living in the world.
- **Be ethical:** All counselors should practice ethical behaviors in their counseling relationships, with some of the more important ethical issues for helpers who practice reality therapy being including professional disclosure statements, obtaining informed consent, and ensuring that they avoid dual relationships.
- **Create anticipation:** Therapists who use reality therapy enter the relationship with optimism and a sense that clients can and will change. This sense of anticipation and hope can be seen in both the verbal and nonverbal communication of the helper, is contagious, and it instills optimism and a desire for change in the client.
- **Practice lead management, discuss quality, and increase choices:** These three elements are particularly important when using reality therapy in organizations (schools, workplaces, etc.). These qualities speak to the importance of having a leader in the setting who is nonauthoritarian and noncoercive and who encourages an atmosphere that is respectful, democratic, participatory, transparent, and appreciative of differentness and one in which there is a sense that individuals have choices concerning their behaviors.
- **Discuss quality:** As clients begin to examine their quality world have them look at whether the choices they have made have been destructive in meeting their needs.
- **Increase choices:** As clients realize the destructive choices they have made in meeting their needs, help them increase choices, so they can choose healthier ones in meeting their needs.
- **Discuss problems in the past tense and solutions in present or future tenses:** Focusing on the past tends to mire one in past symptoms and complaints. Thus, reality therapists tend to focus on the present and the future. Although it may sometimes be prudent to focus on the past in an effort to strengthen the relationship, generally, the emphasis of therapy should be on changing behaviors that are currently preventing the client from getting what they want and need.
- **Withdraw from volatile situations if helpful:** Counselors need to know how to not become drawn into volatile client situations and teach clients how to pull out of such situations in their lives. Volatility in relationships generally leads to control issues and discontent.
- **Talk about nonproblem areas:** Like withdrawing from volatile situations, sometimes it's prudent not to talk about problems, as "problem talk" sometimes leads to an ongoing focus on the problem. Instead, it is often best to focus on nonproblem areas and solutions.
- **Connect with the person's thinking and feeling:** Reality therapists are encouraged to focus on thinking and feeling and how destructive behaviors are not allowing the client to think and feel in ways that they want.
- **Invite solutions:** Instead of focusing on the past or spending an inordinate amount of time discussing their problems, clients are invited to focus on solutions that can more effectively meet their needs.
- **Use the broken-record technique:** Counselors should be committed to their clients and continually help them focus on directing their lives toward new ways of behaving that better meets their needs.
- **Use affirming language:** Counselors are at their best when they use caring language, are positive, and affirm the work of their clients.
- **Use questions and explorations:** Questions are particularly important in helping clients discover their wants and evaluating how effectively they are moving in the direction that will meet their needs in healthy ways. Some examples of these are highlighted in the therapeutic process section that follows.

Toxins of the Helping Relationship

A number of behaviors can go far in destroying a therapeutic relationship and relationships in general. Based on external control, many of these behaviors are similar to those that Glasser highlights in his list of "seven deadly habits" (see Box 10.3). These behaviors should be avoided by counselors and clients alike. Wubbolding (2012) uses the acronym *ABCDEFGH* when discussing each of the following attitudes and behaviors, all of which need little explanation (see Table 10.2).

TABLE 10.2. Toxins of the Helping Relationship: ABCDEFGH

Avoid arguing, attacking, or accusing.	Don't encourage excuses.
Don't boss manage, blame, or belittle.[1]	Don't instill fear or find fault.
Don't criticize, coerce, or condemn.	Don't give up easily or take for granted.
Don't demean or demand.	Don't hold grudges.

1. Often used to explain behaviors in business and in schools by those in power. However, a therapist or a client should avoid these behaviors also.

The Counseling Process

When counselors demonstrate the techniques and embody the attitudes highlighted in the tonics of the helping relationship, clients should be able to successfully involve themselves in the WDEP cycle, which as you remember, includes helping clients discover their wants of the client, reviewing what the client is doing in their life's direction to obtain their wants, evaluating if what the client is doing is working, and developing a plan of action that can be implemented (see Figure 10.4; Wubbolding, 2015c, 2020). The following describes each aspect of this cycle of implementing the WDEP system.

(W) Discovering Wants

In this part of the cycle, counselors are interested in clients fully understanding the kinds of wants in their quality worlds. Typically, counselors will first teach clients about the quality world and how wants become associated with it, discuss issues related to these concepts, and suggest reading materials to elaborate on them. As clients slowly begin to understand the concepts of the quality world and wants, they are better able to identify their unique wants, which are based, if you remember, on the client's individual need-strength profile. Some questions that can be used to clarify client wants include the following:

- We talked about your "quality world" and the kinds of wants that the pictures represent. Can you tell me some of the wants in your world?
- What do you think are some of your most important wants in life?
- What kind of wants do you believe motivate you to do things?
- What is it that you want for your _____?

For the last question, Wubbolding (2000, p. 99) suggests that clients specifically be asked about wants in 10 areas of their lives, including what they want for the following:

- themselves
- job manager, supervisor, or co-workers
- the world around them

- friends and relatives
- therapy process itself
- spouse or partner
- parents, children, teachers, or school
- associates or acquaintances
- religion, spirituality, or higher power
- any institution that impinges their lives

These questions represent a few of the many kinds of responses a counselor can make to help clients begin to understand their quality worlds and explore their wants. Other ways of exploring wants include visualization, journaling, creative tasks (e.g., working with clay), and so forth. As clients gain clarity about their quality worlds and their associated wants, they are in a better position to assess their levels of commitment to the therapeutic process. Wubbolding (2000) suggests there are five levels of commitment that range from "I don't want to be here" to "I'll do whatever it takes." Clarity on commitment by both the client and the therapist will clearly affect how work in therapy proceeds.

(D) Analyzing the Direction in Which the Client is Moving and What the Client Is Doing to Get There

After identifying wants in their client's quality worlds, counselors can begin to ask their clients to describe what they are doing to fulfill their wants.

> So, when partners feel distant from one another, they are asked where they are headed: towards a better relationship or towards separation. The chemically dependent person can be asked, "If your use of drugs continues to increase at the current rate, where will you be in five years?" The student who refuses to study or who makes little attempt to get along in the school can be asked, "If you continue down this same pathway, where will you be at the end of the school year?" (Wubbolding & Brickell, 2015, p. 60)

It is at this point that clients begin to identify what they are doing to have their wants in their quality worlds fulfilled. Using the examples just given, and if the first individual states they want to have a better relationship, the second wants to stop using, and the third wants to do well in school, here are examples of questions that can be asked to help clients identify how they are going about trying to have their wants fulfilled:

- Can you describe your day to me and tell me what you did, or did not do, to make your relationship more of what you want it to be?
- You're saying you're wanting to stop using; take me through your typical day and what you have done, or not done, to make yourself move in that direction.
- So school has not been working for you; tell me what a typical day looks like and what you do to make friends and to study.

(E) Self-Evaluation Techniques

> The essential aspect of self-evaluation is a personal, inner judgement about behaviour or "quality world" wants. (Wubbolding & Brickell, 2015, p. 65)

After identifying what clients are doing to have their wants fulfilled, they can begin the process of evaluating if what they are doing is working for them; that is, if what they are doing is successfully

meeting their needs as identified by their wants in their quality world (Wubbolding, 2017, 2020). For instance, the client who wants a better relationship with their lover might write in a journal all their interactions during one day with their lover, only to discover they talk to their lover critically and do not find alone time with them. The chemically dependent person might make a list of times they use and who they are around and realize they spend more time around enablers than other people. And the student might write down all the free times they have and the ways they interact with other students and find out they spend little time studying and make virtually no attempts to be friendly with fellow students.

There are an endless number of techniques clients can use to help them examine if what they are doing is working for them. Although behaviors are often the easiest and most direct method of examining the effectiveness of meeting one's wants, examining feelings and physiological responses can also be used. Box 10.7 offers just a few examples of how clients can evaluate whether what they are doing is working for them.

BOX 10.7 Select Techniques to Evaluate Whether Client Is Having Wants Fulfilled

1. **Asking the client specific questions**

   Counselors can ask clients to engage in evaluation of their behaviors by asking them specific questions, such as the following:

   a. "Is what you're doing working for you?"
   b. "Has that behavior been helpful in having your wants fulfilled?"
   c. "Have the choices you made moved you in the direction you've wanted to go in life?"

2. **Suggesting the client do self-reflection**

   Clients can be asked to find time during the week to reflect on their lives and consider if what they are doing is working for them.

3. **Using a behavioral checklist**

   Clients can be given a behavioral checklist and check those behaviors that are positive and those that are negative in reference to getting their wants fulfilled.

4. **Using a "feeling word" checklist**

   Clients can be given a "feeling word" checklist and identify which feelings they have most often and examine what behaviors are associated with those feelings. Behaviors associated with negative feelings can be evaluated and new behaviors that lead to better feelings chosen.

5. **Monitoring thoughts**

   Clients can monitor and identify which thoughts are associated with particular actions and whether those specific thoughts are effective at getting their wants fulfilled.

6. **Physiological monitoring**

   Clients can be asked to take periodic blood pressure readings and note what actions or thoughts are associated with a rise or fall in blood pressure. High blood pressure readings may be associated with inefficient ways of having a specific want fulfilled.

(P) Make Specific, Workable Plans

As clients begin to focus on the changes they want to make, in collaboration with the counselor, they can develop a plan to change what they are doing (Fulkerson, 2015; Wubbolding, 2015c, 2020). Counselors should use tactful and careful language when assisting clients in developing a plan, and plans should be only developed when the client is ready:

> The mistake made by neophyte, and even at times experienced practitioners of reality therapy, is to impose a plan too quickly or an unwilling or resistant person or to indulge in paternalistic (or materialistic) advice giving. (Wubbolding, 2000, p. 151)

Wubbolding (2012) identifies three levels of planning: those initiated solely by the client, those developed with the counselor, and those developed by the counselor. Although all are acceptable, Wubbolding suggests that, generally, those initiated solely by the client are most effective (see Figure 10.5).

Wubbolding (2020) suggests two types of plans: those that are linear and those that are paradoxical. *Linear plans* are to the point; they address the problem directly and are often client-initiated. For instance, if a client wants to have a better relationship and finds they are spending little time with their partner, a linear plan would be to focus directly on finding ways to make more time. *Paradoxical plans*, on the other hand, work with the problem indirectly and are generally counselor-initiated. For example, a client who is constantly worrying about others and, therefore, not able to build friendships, is told to spend more time worrying about others and to write down all their worries. This has the effect of the client realizing the ridiculousness of their problem.

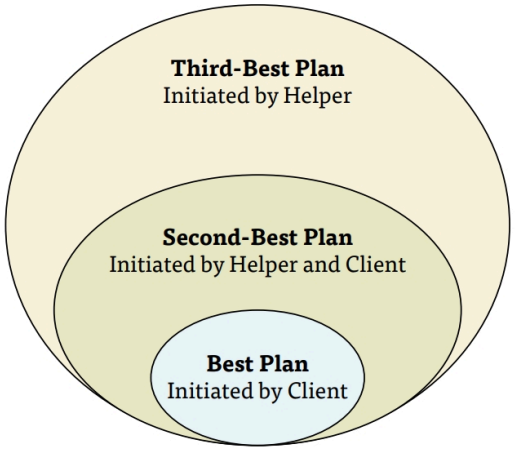

FIGURE 10.5 Effectiveness of Plans

Plans come in many shapes and sizes, and whatever type of plan is decided upon needs to be workable. Wubbolding (2012, 2020) uses the acronym *SAMI2C3* to examine whether a plan is workable. Using this acronym, the plan should be as follows:

- **S:** simple (unambiguous and clear)
- **A:** attainable (realistic and doable)
- **M:** measurable (exact and clear about when it will take place)
- **I:** immediate (completed as quickly as possible)
- **I:** involved (the therapist is involved with the plan as needed)
- **C:** consistent (can be repeated if necessary)
- **C:** controlled (the client is in the driver's seat)
- **C:** committed (client is dedicated to doing the plan)

Finally, it should be remembered that plans are not set in stone but are a road map for how the client might change. If the plan is not effective, counselors should discuss with the client why it was not workable and, when necessary, help the client devise a new plan.

A Final Word About the WDEP System

Is important to remember that when using the WDEP system, clients can revisit any aspect of the cycle at any point in the change process. Thus, clients may want to suddenly take a new look at

the wants, reexamine their direction and what they are doing, reevaluate their progress, or make new plans. Whatever clients decide to do, the therapist should be committed to the client and never give up helping the client make new choices that will lead to a life with greater satisfaction.

Social, Cultural, and Spiritual Issues

Reality therapy can be helpful to diverse clients because it tends to be a short-term, positive, and respectful approach that helps clients focus on the control they have over their world, rather than the actions and thoughts of others. It accomplishes this by focusing on solving present problems, improving relationships, and developing the skills to make better life choices. Therefore, clients are less likely to feel negatively impacted by external control language and oppressive actions taken by others (Wubbolding, 2012, 2019b).

Although reality therapy acknowledges discrimination, oppression, and marginalization, it suggests that one's responses to those external toxic behaviors are maladaptive when they result in thoughts and behaviors that prevent a client from meeting their inherent need-strength profile in positive ways (Haskins & Appling, 2017; Wubbolding, 2019b). Thus, it helps clients find new ways to respond to such toxic behaviors that result in more positive feelings and less stress. Thus, culturally diverse clients are not viewed as inherently marginalized, but as people who exist within a marginalizing environment that they can adapt to and change as they engage in more healthy total behavior responses. Throughout this process, counselors develop a strong therapeutic alliance in which clients can test new behaviors, challenge their cognitions, express themselves authentically, and develop more adaptive total behaviors, while creating a new positive quality world.

Culturally responsive counselors seek to understand the client's quality world, as well as external barriers (e.g., discrimination or oppression), so they can best understand their experiences of the world and help them move from external to internal control of their total behavior. For example, a counselor working with a client living in poverty can be helped by gaining awareness and knowledge about the structural and dispositional origins of poverty and empowered by changing their quality world so they can find the best ways to combat poverty and meet their needs, wherever possible. Areas of dismantling poverty can include facilitating client skill development (e.g., job seeking skills, literacy skills, and social advocacy) and building relationships with community partners who can support clients in behaviors that can better their lives.

As counselors engage in culturally responsive interventions, they empower their clients to meet their five basic needs in ways that foster a positive quality world. These new and more positive ways of meeting one's needs can be applied at the family, community, and societal levels. Table 10.3 provides examples of how culturally responsive counselors can foster this process.

TABLE 10.3. Sample Culturally Responsive Interventions

Basic need	Sample interventions
Survival (self-preservation)	Refer clients to community resources to support food security, shelter, safety, and health and wellness.
Love and belonging	Help clients connect or reconnect with affirming support people and systems they choose to put in their lives.
Power (inner control)	Identify and leverage cultural strengths (e.g., spirituality and resilience) and ways of knowing to codevelop client goals and test new behaviors that offer clients a sense of strength and agency.
Freedom (independence)	Facilitate skill development (e.g., advocacy, career, and social) to provide clients with tools they can use to counteract oppressive experiences.
Fun (enjoyment)	Identify client individual, familial, and social activities in which they feel enjoyment which, in turn, supports psychological and physical health.

As a foundation of culturally responsive practice, counselors need to intensively engage in understanding their own quality world. For instance, counselors should ask themselves what pictures they hold in their quality world about themselves, diverse and marginalized people, and society and how those pictures maintain certain behaviors, cognitions, feelings, and physiological responses. This process of self-reflection can help counselors focus on their intersecting cultural identities and experiences of privilege and oppression and how these may intersect with a presenting problem they encounter with a particular client. For example, imagine a White, heterosexual, woman counselor, who is working with a Black lesbian client presenting with a diagnosis of anorexia nervosa. How has the counselor experienced disordered eating behaviors in her own life? What does disordered eating look like for her? What stereotypical images does she hold about those who engage in disordered eating (e.g., White, heterosexual, upper middle class)? What predispositional images does she maintain about lesbian women, Black women, and women with eating disorders? To what extent has her reality been determined by her intersecting cultural identities and experiences with privilege and oppression, and how does that shape how she has chosen to interact in her own environments as well as with clients?

Although religion and spirituality are rarely discussed in most of Glasser's writings, it does support some religious concepts, the most important being the recognition that we have been afforded free will to make good or bad choices in our lives (Dziordz, 2019; Parish & Parish, 2019). In addition to the Golden Rule noted earlier (see Box 10.2), scriptures and other sacred writings commonly use examples of choice and consequences that can be infused in culturally responsive practice when it reinforces a positive quality world (Parish & Parish, 2019).

For religious clients who believe there is external truth, reality therapy may be problematic, with its adherence to the belief that reality is the result of the choices we make and not based on external truth. On the other hand, reality therapy can help reinforce an important existing religious belief in a person's quality world when that belief positively reinforces an important need that hasn't been fully met. For instance, the belief that we should unconditionally love others can be an important picture in one's quality world when a person has a strong need to for love and belonging (Dunkin, 2019). Finally, Wubbolding suggests that reality therapy should strive to be more inclusive of those with strong religious beliefs and spiritual values and suggests that, perhaps, the need for purpose, meaning, and faith should be added to the five existing needs of reality therapy (Wubbolding, personal communication, May 10, 2016).

Reality therapy has been applied to cultures internationally (e.g., Ebadi et al., 2020; Farhadi et al., 2020; Jusoh, 2018; Law & Guo, 2017; Misztal, 2010; Moridi et al., 2020; Rosidi et al., 2019). Regional and national organizations that collectively comprise the William Glasser Institute International conduct trainings in more than 36 countries and regions (William Glasser International, n.d.a; Wubbolding, 2019b; Zalaquett & Wubbolding, 2016). This fact illustrates the multicultural application and acceptability of choice theory and reality therapy. However, despite its widespread use, some suggest that reality therapy embraces too many Western values, such as the fact that an individual's strife is almost always of one's own making and that there is almost always a focus on individual change at the expense of a client's extended family or community. What do you think?

Efficacy of Reality Therapy

Reality therapy, with its focus on problem-solving and empowerment of individual choice, has been shown effective for a variety of mental health disorders (William Glasser International, n.d.b; Wubbolding, 2012). For more than four decades, the *International Journal of Choice Theory and Reality Therapy* (IJCTRT), an open-access online journal, has disseminated scholarship on the practice of reality therapy across the globe. Counselors interested in using reality therapy are encouraged to review scholarship from this source regularly.

Like other cognitive-behavioral approaches discussed in this section of the text, reality therapy has been demonstrated as effective across diverse populations and clinical and school settings (e.g., Graham et al., 2013; Haskins & Appling, 2017; Mason, 2016; Mason et al., 2019; Mickel, 2013; Royle & Brown, 2014). In addition, reality therapy has been identified as an evidence-based approach by the National Registry of Evidence-Based Programs and Practices (NREBPP; see Substance Abuse and Mental Health Service Administration, n.d.).

Resources such as the William Glasser Institute, the IJCTRT, and the NREBPP are useful for examining specific studies demonstrating its efficacy. In reviewing studies, counselors are to be mindful of the study sample characteristics and any design limitations as they seek to generalize findings to their own practice. The following offers some of the issues that have been positively addressed through the use of reality therapy (see Ebadi et al., 2020; Farhadi et al., 2020; Hajhosseini, 2016; Handy, 2015; Mickel, 2013; Nayeri et al., 2021; Pouravari et al., 2018; Royle & Brown, 2014; Supeni & Jusoh, 2021; Wubbolding, 2012):

- depression and anxiety symptoms
- stress management
- psychosomatic disorders symptoms
- psychotic disorders symptoms
- marital satisfaction and intimacy
- intimate partner violence and other domestic violence
- youth relational and physical aggression
- academic procrastination
- k–12 opportunity gaps
- student self-concept
- youth sexual misconduct
- attention-deficit/hyperactivity disorder symptoms
- oppositional defiant disorder symptoms
- substance use disorder symptoms
- recidivism for juvenile offenders
- chronic pain
- exercise and physical activity

Like efficacy research on other counseling and psychotherapy theories presented in this text, additional research is needed. For example, with the increasing diversification of the United States partially influenced by immigrants and refugees with varying migration histories and levels of acculturation, there is ample opportunity to include more diverse samples and report findings from reality therapy research with greater specificity in terms of sample characteristics. In addition, most available research regarding reality therapy does not involve randomly controlled trials, meta-analyses and systematic reviews, replication studies, or qualitative studies with complex analyses and reporting. With what many view as reality therapy's "anti-medication" and "anti-diagnosis" stance, studies examining concurrent mental health and medical treatments are severely lacking.

The Millers

The following shows Markus going through reality therapy. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Markus Meets a Reality Therapist

Angela rapped loudly on the heavy door for a third time before finally letting herself in. "Markus! Markus! It's me, Angela! Are you up?" Angela made her way past stacks of newspaper, dozens of books, plates with shriveled pizza, and several discarded beer bottles of soda and beer.

Angela recoiled internally at the stale smell that hung in the air, noting the dust that seemed to dance in the narrow light streaming in beneath the tightly drawn shades. "Hey, Markus, come on, it's me." Angela found Markus lying on his bed, staring at the ceiling. "Come on, Markus, we have an appointment."

Once in the car, Markus asked, "Where are we going? I don't remember having an appointment." Angela watched the light change and pulled into the intersection. "We are going to see a counselor. His name is Mike Watkins. I know you liked Dr. Bertram, but she is on some kind of sabbatical or something, and you need someone right now." Angela turned right and slowed the car. "We are looking for 307 Second Street, Markus. Keep your eyes peeled."

Mike Watkins's office was a cramped space in a belowground office. A vaguely musty smell reminded Angela of Markus's apartment. Mike offered Markus a seat and indicated that Angela should wait in the lobby.

"Mike—right?" Markus began. "I didn't know Angela was bringing me here until we pulled into the parking lot. I don't really know what to say." Sitting back in his chair, Mike waited for Markus to continue. "My partner, Rob, left a month ago. I don't mean he left for good, just that his company got him working in the Middle East on a government project, and he won't be back for five months. I asked him not to go, but he's sure it will be good for his career."

"Rob's absence feels important. Can you help me understand how Rob being gone fits with why you are here, or why you think Angela brought you?" Mike probed.

"I guess she's worried. After Rob left, something just clicked, or maybe unclicked, and now I can't seem to focus on anything. Sometimes, I feel like I can't move or even think. Angela's worried about my comps." Mike looked confused, and Markus continued, "I'm working on my PhD, and I have a series of papers to write for my comps. To be honest, I don't know how I'll get myself together in time to submit to my committee. I spent the whole morning staring at the ceiling, and I'd probably still be there if Angela hadn't dragged me out of bed." Markus threw his hands up in frustration. "I have one task to do—write those papers. It's not a big thing. I'm worthless! I'm asked to do one thing, and I can't do anything but sit on my butt."

"That's a lot of pressure, Markus—comps on one hand and wondering what Rob is thinking about your relationship on the other. No wonder you've been thrown off-kilter. It seems to tap into two basic human needs: the need to love and be able to count on love from others and the need to feel like you're succeeding at something worthwhile—in this case, your comps." Mike scratched his head, considering the problem. "No wonder you've been struggling lately."

"That's about the size of it. It sounds like an old country song, but that's how it's been," Markus said, relaxing into his chair.

"Markus, as you've been going over these concerns about Rob and with your comps, have you given much thought to the image of how your life would look if everything was ideal? What would your quality world look like?" Mike asked, curious to understand Markus a little bit better.

"I'm sorry," Markus asked, "quality world?"

"A quality world is the world as you would like it to be if you were fulfilled and happy," Mike clarified.

"Oh, sure, okay. Well, Rob would be here. He wouldn't have left in the first place because our relationship would be more important than his damn career! He knew I was in the middle of preparing for my comps. I don't know why he felt like he had to leave now. How am I supposed to think straight with him halfway across the world? That's the part that keeps going through my mind. I wonder if he's just going to pack up and leave any time something comes up at work. Is our relationship always going to be second for him? I think about that a lot."

"And how would it be if your relationship was not second and things were just as you'd like them to be?"

"We'd have a house with kids. I would have a job teaching at a university, like my dad did. I guess that is what I'm looking for. My dad had a good life, happy family, and a solid career teaching, and time to take trips to Nigeria in the summer. I want that for us, too. Not Nigeria necessarily, but our own life that is ours outside of work. Does that make sense?"

As Mike reflected on his first session with Markus, he considered what he had learned about his new client. A reality therapist, Mike is interested in the basic needs that Markus is working to fulfill. Mike noted that Markus tended to use language that portrays how he feels controlled by others and outside events, such as his belief that he can't think straight while Rob is away. Mike hopes that in the upcoming sessions, he can help Markus choose behaviors and language that will help him satisfy his needs in his quality world in effective ways. Mike noted in Markus's chart that he had given Markus some material to read that describes five basic needs: survival, love and belongingness, power, freedom, and fun. He has also given Markus some readings about total behavior and the role of behavior in making productive choices to meet basic needs.

When Markus arrived for his second session, Mike shook his hand and gestured to a chair. "No Angela today?" he commented.

"No, I thought I could get myself here this morning, though she did call last night and this morning to remind me. Angela has this caretaker thing going on." Markus and Mike laughed as Markus settled into a tattered chair beneath the ground-level window. "I read the material you gave me, and I was thinking a lot about those basic needs. I never thought of my work on my comps as meeting power needs, but I guess that is what that is, right? If I pass the comps, I have a sense of achievement—and I guess I feel powerful. But Mike, I'm at a place right now where it will be a miracle if I can get my comps written before the deadline; I have five weeks to finish all three topics. If I fail my comps … I'll feel completely worthless."

"That puts some pretty high stakes on turning this thing around." Mike leaned forward in his chair. "Did you read anything in that packet I gave you that might help?"

"I've been thinking on and off about the idea that control comes from within and not outside us, but I can tell you that is a lot easier to talk about than to do. I think about the way that Rob being gone has me so depressed and how hard it is for me to do anything, and I just don't know how I'm supposed to control that."

"Markus, maybe part of having control starts with how you think about your obstacles and next with how you talk about them." Mike noticed Markus's confused look and continued. "You've said Rob being gone has me so depressed it is hard for me to do anything. Maybe you can take back some of your control by thinking of it like this: I've chosen to depress myself and to do little else than think about Rob being gone."

"When you say it like that, Mike, I feel like you are saying that I am to blame for being so depressed. I don't like the way that feels. I love Rob, and it is really hard to have him gone when I need him so much right now."

"What if it wasn't about blame? For instance, how do you hear these two things differently?" Mike asked. "I have writer's block compared to I'm choosing not to write, right now."

"Well, in one way, the first one, about the writer's block, sounds like it's not my fault that I can't write, but something that happened to me. But on the other hand, the second statement makes it sound like I'm the one who's stopping me from writing." Markus thought for a moment, "I guess, in a way, the second one sounds more hopeful because if I am the one in charge, not this thing called 'writer's block,' then I choose whether or not I write … but I have to take responsibility for it in that case."

"Then, you see my point. If you take a look at the problem from the standpoint of something happening to you, like writer's block, you have little power over it—you have to wait for it to go away. But, if you decide to look at it from a perspective of something happening within you, a choice in

the way you approach your struggle, then you have your control back. I call that 'internal control' because you are the one who is in the driver's seat. Internal control means that if you choose to, you could pick up your pencil and write, right now—right here."

"What, here? Right now?" Markus laughed.

Mike shrugged, reaching into his desk, taking out a pad and pencil, and handed it to Markus. "Why not? The consequences for not writing—what are they? You have time to think about your relationship with Rob, but your comps are due in five weeks. From where I'm sitting, you have a couple of choices: You can write or not write, but only one of those choices is going to get you any closer to your dream of teaching at a university."

Mike was certainly surprised when Markus took the last 20 minutes of their session to write an outline for his first paper. Markus seemed to respond well to prompts from others; he came to counseling with his sister's prompting and was able to write given a little prompting. Mike would like to help Markus gain a sense of his own efficacy—to see solutions as arising from within, out of his own efforts, and not from Rob, Angela, or his counselor.

As the session came to an end, Mike began to teach Markus about the WDEP system. He gave Markus reading materials and let Markus know they would begin their next session by discussing Markus' quality world, his wants, the direction he is going in, what he is doing to get there, and evaluating what he is doing. Mike hoped to encourage Markus to evaluate how his behavior has worked toward and against his dreams. Ultimately, Mike hoped to help Markus create a plan of action that would help to bring his wants to fruition.

As the next session began, Mike said, "I was hoping we could spend some more time talking about what it is you want for yourself, Markus, and some about the direction you are taking to make those wants a reality. Did you have a chance to read the materials I gave you?"

"I did, and it got me thinking some. Not just about me and my relationship with Rob but also about my relationship with my sister, Angela, and my parents. Sometimes I feel like no matter how old I am, I am still the kid brother, you know? Every relationship I have has some element of somebody helping me in some way, prodding me along. I thought about that for a long time, and I know that when people take care of me, that's when I feel loved," Markus began.

"It helps to meet your need for love and belongingness," Mike added.

"Yep. But there is this other side to it. When other people help get me through a rough spot and I accomplish something thanks to their help—I don't know, it doesn't feel right. It is like it isn't mine anymore. Does that make sense?" Markus asked.

"You mean like that need to feel like you accomplished something gets diminished somehow?"

"Yes, like it isn't my accomplishment anymore. Now, if I get through my comps it will be because Angela brought me here and because you handed me that pad of paper. Don't get me wrong, it helped to have that little push, but I want to stand on my own two feet. I can't go through life waiting for Rob and Angela or even you to get me going," Markus explained.

"Well, Markus, when you look at the doing and direction part that was described in the literature I gave you, did you think of anything that you are doing that is contributing to this experience?" Mike asked.

"I think I know that Angela is my safety net. If I start to fall, she will be there to catch me, just like she did a couple of weeks ago. Something about Angela, well, taking care of others, that's important to her. But Rob ... it bugs him. I feel like I may have driven him away by leaning on him for all my direction and answers. In fact, it seems like the very thing I do—act all dependent on Rob—is the very thing that drives him away. And it's the very thing that makes me not feel accomplished because I often feel like others are doing for me and I'm not doing for myself." Markus thought a moment and added, "I feel good about getting myself here this week, though. Angela didn't have to come by and get me. I've done this on my own, at least today. And last night, I found a study app for my phone that keeps a timer and told myself to write until the timer went off. It worked pretty well, so I feel good about that."

"The way you've described it, Markus, you've evaluated your direction and doing for yourself, you've decided what is working, monitoring yourself with a study app, for example, and things that haven't worked so well, like leaning too heavily on Rob and Angela for motivation and direction." Mike paused briefly. "I suspect that, somehow, you learned in the past that you could meet your need for love and belonging by being dependent on others. However, in the long run, being dependent on others hasn't really gotten you what you want—which is a more mature sense of love and belonging with your partner and a sense of accomplishment for yourself. I wonder if you had any thoughts about how you might shape your behavior in the coming weeks to get you through your comps and help you navigate your relationship with Rob and your family."

"Well, right now, my focus needs to be on completing my comps. I want to feel like this was my accomplishment when I graduate. I think that by making a writing schedule, using my timer to pace myself, and really sticking to it; I know I can finish. The relationships, though, that is the harder part. I think I could use your help to understand that better before I make a plan for what to do differently," Markus offered.

"I agree, Markus; spending some time understanding those relationships better would really help you understand yourself better and might even help you imagine more clearly what it is that you want from them and how you can get it."

As Mike began his session notes, he felt hopeful for Markus. Markus was beginning to cultivate internal control language and has the beginnings of a sense of the relationship between his wants, the direction he has been moving toward, and the manner in which he has attempted to fulfill his needs in the past. Mike feels certain that with more work, Markus will create the life he wants for himself.

For You to Consider

1. What techniques do you think are most important in building a relationship with Markus, while helping him to understand the basic principles of reality therapy?
2. How important do you think it is to explore Markus's past, especially how it relates to his ability to have his need for love and belonging met?
3. Do you believe Markus can move forward and work on his issues with little or no discussion of his past?
4. Since reality therapists believe that just about all emotional problems are self-made, if Markus came in extremely depressed and suicidal, can a reality therapist justify referring Markus for medication to help relieve the depression?
5. If Markus continues not to take responsibility for his feelings, how far should a reality therapist go in confronting his lack of taking responsibility for his emotional state?
6. Do you believe that Markus's depression is only of his doing, or do you think that outside circumstances have had some effect on how he feels?
7. If you were to continue as Markus's reality therapist, how might you use the WDEP system to support him in exploring and creating a plan to strengthen his relationships?
8. What multicultural issues does Markus's counselor need to attend to?
9. If Markus becomes more independent, how might his relationship with Angela change? How might Angela experience these changes?
10. If Markus becomes more independent, how might his relationship with Rob change? How might Rob experience these changes?

Summary

William Glasser, the creator of reality therapy, grew up in Cleveland, Ohio with parents whom he describes as having a tumultuous relationship. Despite his parents' arguing, he remembers them as being loving toward him. He also remembers several important people who mentored him along his way. Although Glasser was trained in psychoanalysis, he questioned many basic notions of analytical therapy and created a novel and revolutionary approach to counseling that was antideterministic and present-focused, and he had a belief in the ability of the person to make changes. With influences from Powers's perceptual control theory and Deming's total quality management theory, Glasser would eventually develop reality therapy based on choice theory, which was used in schools, business, and counseling settings. Some people who helped Glasser to shape his theory over the years were his first wife, Naomi Glasser; his second wife, Carleen Glasser; and Bob Wubbolding, who expanded on Glasser's ideas.

Choice theory, the basis of reality therapy, suggests there are five basic needs, including survival (self-preservation), love and belonging, power (inner control), freedom (independence), and fun (enjoyment), all of which help humans survive and thrive. Each individual has a genetically based need-strength profile, which is fixed at birth. The choices we make in an effort to fulfill these needs are represented by pictures in our quality worlds. Glasser suggested that an individual's "total behavior" is chosen and generated from within in an effort to match the pictures in their quality world. Total behavior includes our actions, our thinking process, our feelings, and our physiological responses. However, we can only actively change our actions and thoughts, which Glasser jointly called what we are "doing." Our feelings and physiology result from those choices. Glasser suggested that the individual operates from an internal control position, although many people mistakenly believe they are externally controlled. One goal of therapy is to move clients from an external to an internal control philosophy and for the clients to adopt the seven caring habits as opposed to living by the seven deadly habits. The basic ideas of choice theory are summarized through Glasser's 10 axioms, which are an outgrowth of five concepts central to the understanding of choice theory: basic needs, internal control, choice, quality world, and total behavior.

The standard method of implementing reality therapy, using choice theory, is the WDEP system. To build a trusting relationship, the counselor demonstrates the tonics of the helping relationship and avoids the toxins of the helping relationship. The attitudes and skills of the tonics of the relationship should be exhibited throughout the implementation of the procedures of the WDEP system, which includes the wants of the client (W), what the client is doing in their life's direction (Ds), evaluating if what the client is doing is working (E), and developing a plan of action that can be implemented (P).

Relative to social and cultural issues, it was suggested that this approach can help diverse clients because it is short-term, positive, and respectful and can help them understand how they can adapt their quality world to discrimination, oppression, and marginalization, while meeting their five basic needs. It was suggested that counselors should examine their quality world to see how they can better understand their own sense of privilege and oppression. It was also noted that reality therapy has been applied to many cultures internationally, although some suggest it may embrace too many traditional Western values. Relative to religious and spiritual issues, reality therapy recognizes the importance of the universality of the Golden Rule and other religious scriptures when making choices. For religious clients who believe there is external truth, reality therapy may be problematic, with its adherence to the belief that reality is the result of the choices we make and not based on external truth. On the other hand, reality therapy can help reinforce an important, positive, existing religious belief system in a person's quality world. Wubbolding suggests that, perhaps, reality therapy needs to add an additional fundamental need—the need for purpose, meaning, and faith.

Finally, reality therapy has been demonstrated to be effective at both a national and international level with a variety of mental health and psychosocial problems. However, randomly controlled

trials, meta-analyses and systematic reviews, replication studies, and complex qualitative study designs are needed, along with greater attention to diversity, and the use of medications with and without reality therapy, in study design and reporting.

Key Words and Terms

ABCDEFGH
acting
antideterministic
basic needs
choice
choice theory
control theory
(D) analyzing direction and what the client is doing
doing
(E) self-evaluation techniques
external control
external control language
feeling
freedom (or independence)
fun (or enjoyment) need
Golden Rule, the
here and now
internal control
internal control language
linear plans
love and belonging need
needs
need-strength profile
(P) make specific workable plans
paradoxical plans
perceptual control theory
physiology
power (or inner control) need
quality world
reality therapy
SAMI2C3
seven caring habits
seven deadly habits
survival (or self-preservation) need
10 axioms of choice theory
thinking
tonics of the helping relationship
total behavior
total quality management (TQM)
toxins of the helping relationship
(W) discovering wants
wants
WDEP system

Key Names

Deming, Edward
Glasser, Carleen
Glasser, Martin
Glasser, Naomi
Glasser, William
Harrington, G. L.
Powers, William T.
Sheehan, Ms.
Szasz, Thomas
Wubbolding, Bob

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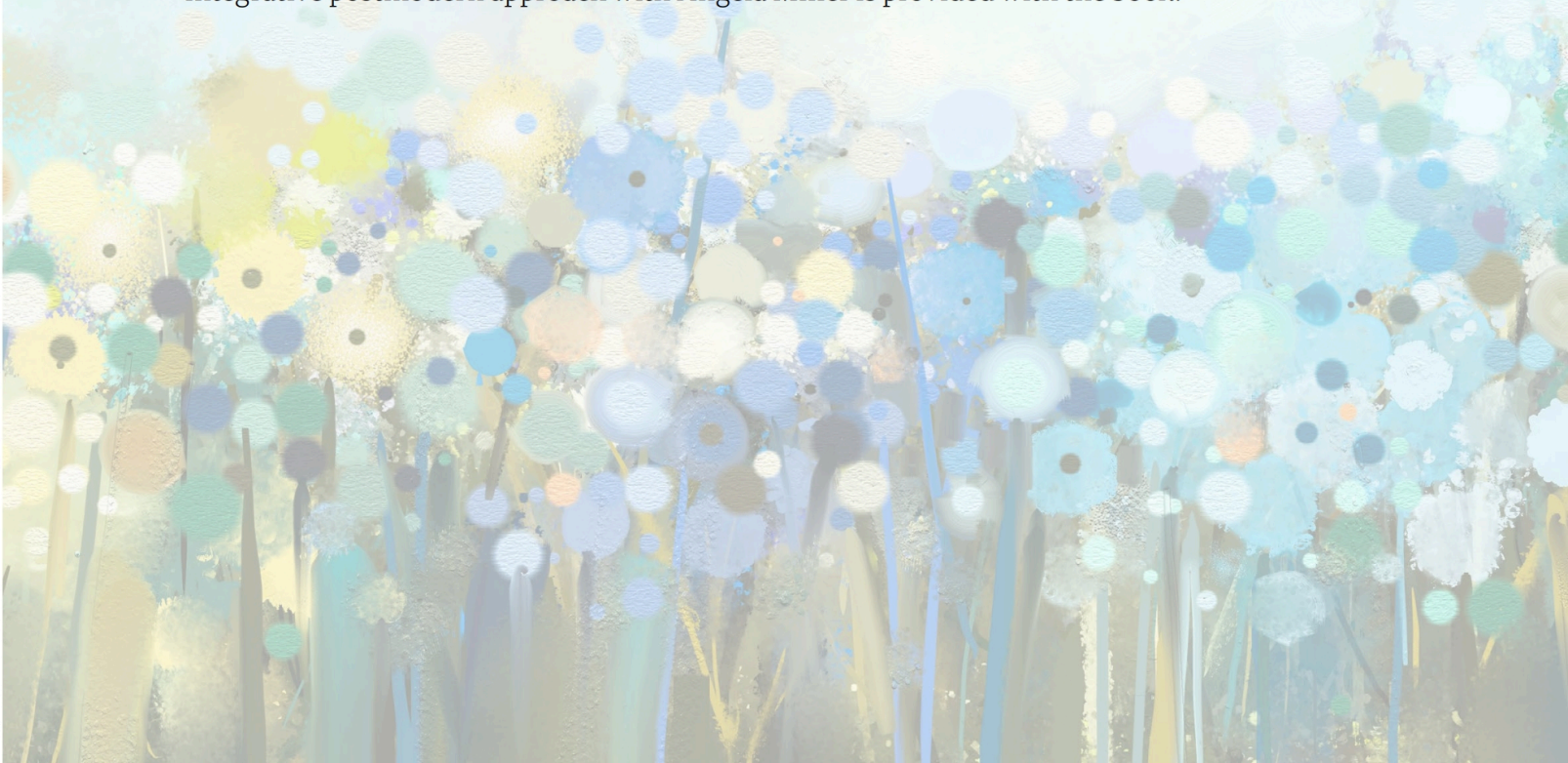
SECTION IV

POSTMODERN APPROACHES

Narrative therapy, solution-focused brief therapy, and relational–cultural therapy are based on the philosophies of social constructionism and postmodernism. Social constructionism suggests that individuals construct meaning in their lives from the discourses they have with others and the language that is used in their culture and in society. Postmodernism suggests that no one reality holds the truth, and we should question many of the past assumptions we took for fact. Those espousing this philosophy even doubt many of the basic assumptions of past popular therapies, which suggest that certain structures cause mental health problems (e.g., id, ego, superego, core beliefs, and lack of internal locus of control). Rather than harp on past problems that tend to be embedded in oppressive belief systems, postmodern approaches suggest that clients can find exceptions to their problems and develop creative solutions and new ways of understanding their world. Postmodern approaches tend to be shorter-term therapies as compared to their predecessors with solution-focused brief therapy being considered a particularly short-term approach, sometimes lasting fewer than five sessions.

Accompanying this text is a video file that provides a role-play for each therapeutic approach being presented in Chapters 2 through 13. In addition, a separate video file that illustrates an integrative postmodern approach with Angela Miller is provided with the book.



11 Narrative Therapy

Learning Goals

At the conclusion of the chapter, readers will:

- learn about the life of Michael White and the historical context in which he created narrative therapy
- understand the constructionist, postmodern, and post-structuralist influences on the antideterministic, antiobjectivist view of human nature of narrative therapy and see how they reflect the ideas that realities are socially constructed, realities are constituted through language, realities are organized and maintained through narrative, and there are no essential truths
- review the following key concepts related to narrative therapy: postmodernism, post-structuralism, social constructionism, narratives, dominant and problem-saturated stories, deconstruction, thin or thick descriptions, relativism, power, unique outcomes, re-authoring, and lack of neutrality
- review a number of important techniques used in narrative therapy, including showing mystery, respectful curiosity, and awe; use of questions; collaboration and reflexivity; reflection, empathy, and verbatim responses; encouraging clients to tell their stories; externalizing the problem and mapping its effects; having clients identify unique outcomes or exceptions; absent but implicit listening and double listening; considering social and political issues; scaffolding; use of therapeutic documents and other paraphernalia; re-membering; definitional ceremonies; reflective teams; and telling and retelling
- understand the four broad phases of narrative therapy, which include joining, examining patterns, re-authoring, and moving on
- examine social and cultural issues, especially in light of how language is used in the creation of reality and how transmission of values from those in power tends to oppress people from nondominant groups, such as individuals of color; women; gay people, lesbian and bisexual people; and other historically oppressed groups
- understand the relationship between the philosophical underpinnings of narrative therapy and the social justice stance that most narrative therapists take
- examine how, for those who experience their religions as oppressive, their spiritual lives can be "re-storied"
- examine biases in research, and discuss the application of quantitative and qualitative research to narrative therapy

> In the late 1970s, Michael published a paper in the prestigious *Journal of Family Process*, reporting on his work with the problem of anorexia at the children's hospital in Adelaide where he worked. The advisory editor (Chris Beels) informed me some years ago that it was the first paper ever published showing positive results with the problem of anorexia. Soon after that, the Deputy Director of Psychiatry obviously heard about this and forbade Michael from meeting with families in which there was a young person diagnosed with anorexia because he was a social worker and was unfit for the task which should be restricted to more august medical and psychiatric practitioners. Michael refused to adhere to this edict and continued to meet with these families and they with him. The next step the Deputy Director took was to remove all the chairs from Michael's room. Michael and the families merely continued, now sitting on the floor. Then the Deputy Director imposed on Michael what I gather he assumed would drive him into some other form of employment, rather smartly, that from then on, he would be allowed only to meet with young people who had failed 2-year-long psychoanalytic treatments for the problem of encopresis or in common parlance, soiling. This was truly dirty work ... Here Michael would be required to turn the tables on conventional psychiatric wisdom and in doing so invent externalizing conversations and in turn narrative therapy. I know Michael once told me he had a 99% success rate in an average of 4 meetings. (Epston, 2008, p. 5)

David Epston, Excerpt from: "Saying Hullo Again: Remembering Michael White," Journal of Systemic Therapies, vol. 27, no. 3. Copyright © 2008 by Guilford Press. Reprinted with permission.

Michael White, a young Australian bachelor's level social worker ultimately changed the manner in which a whole generation of therapists were to work with clients. So well-known did he become that, in 1996, the John F. Kennedy University awarded an honorary Doctorate of Humane Letters, and his books can now be found in multiple languages around the world (Epston, 2008).

In this initial chapter of Section V, we highlight the biography of White, the founder of narrative therapy. We then present the view of human nature from a narrative therapy perspective; key concepts, techniques, and therapeutic processes of narrative therapy; social, cultural, and spiritual considerations; and narrative therapy efficacy research. We conclude the chapter by illustrating this approach with Celia, a member of the Miller family.

Michael Kingsley White

Born in 1948 in Adelaide, Australia, Michael White was not a child you would have imagined would eventually develop a theory that would change the way many modern-day counselors work. This baby boomer came from a working-class home. His father, *Neil*, had served in World War II and was considered more traditional and sometimes strict, and his mother, *Joan*, a "housewife," was viewed as more liberal (Chamberlain, n.d.; Duvall & Young, 2009; *The Guardian*, 2008). She, in particular, would greatly influence her son's life and was seen as loving, compassionate, accepting, hardworking, and hopeful that her children would have opportunities she never did. Michael, the secondborn, had an older sister, *Sue*, who describes herself as the "bookworm" in the family, and two younger siblings: a sister, *Julienne*, and a brother, *Paul*, with whom he was very close (Park & White, 2017). Although suffering from asthma as a child, White was quite active, and he and Paul would spend hours playing and sometimes getting involved in mischievous activities. Often playing soccer together, the family seemed to be close-knit and had an upbeat attitude toward life, and throughout his adult life, White would maintain a relatively close relationship with his family of origin and their offspring. Interestingly, his bouts with asthma seemed to motivate him to become a fitness enthusiast for most of his life. Perhaps his attitude of "turning lemons into lemonade" was one of the reasons he ended up developing a positive approach to therapy.

FIGURE 11.1 Michael White

After high school, White worked as a landscape gardener, laborer, and mechanical draftsman (Park & White, 2017; C. White, 2011). It was also during this time that White began to stand up for perceived injustices as he, along with his older sister and sometimes mother, protested the Vietnam War. In fact, White met his future wife and life-work partner, *Cheryl*, at an anti-war demonstration in 1971. They married in 1972, and Cheryl's ongoing involvement and conversations on feminism and social justice were to be a major influence on White's life and work. White's involvement with Cheryl, his compassionate and liberal mother; involvement in the family environment; and his coming of age during the turmoil of the 1960s all influenced his thoughts about narrative therapy, as well as his eventual focus on social justice issues.

During the early 1970s, White worked briefly as a probation and welfare officer and then went on to become a psychiatric social worker (Madigan, 2015; Pearse, 2008; White, 2007). It was also at this time that White began to deal with his own depression. After being poorly treated and humiliated by the mental health system, White was certain there was a more effective way to work with clients. It was then that he became keenly interested in how clients were often diagnosed and treated in an objective and seemingly inhumane manner and in the inherent power inequities in hospital practices, particularly those between staff and clients (Chamberlain, n.d.).

In 1974, White obtained his Diploma of Technology in Social Work from the University of South Australia and soon after became a senior psychiatric social worker at the Adelaide Children's Hospital in Australia. Here he was encouraged to practice his skills, and he soon was developing innovative ways of working with children, particularly those with anorexia, encopresis (fecal soiling), and night terrors. While at the hospital, he obtained his bachelor's degree in social work (Epston, 2008; Pearse, 2008). It was then that White began to challenge some of the traditional ways in which clients were treated and power was used and abused. In 1978, White and Cheryl had a daughter, *Penni*. A devoted father, White devised fun games with a child who was physically fragile, while Cheryl put her career on hold to be with Penni in her early years, only returning to full-time work later (Chamberlain, personal communication, March 14, 2008).

In 1979, White became the first editor of the *Australian and New Zealand Journal of Family Therapy* (ANZJFT; Denborough, 2009). During the 1970s and early 1980s, he became fascinated with how people communicate in systems and was influenced by such individuals as *Gregory Bateson*, who wrote extensively on this subject (Denborough, 2001; Hart, 1995). White left the hospital setting in 1981 to open a private practice with colleagues at Oxford House. Becoming some of the first private-practice social workers in Australia, they developed training programs on White's emerging theory, which increasingly looked at how systems impact people. During this time, White came up with the notion of *externalizing the problem*, a process whereby clients would name a problem, so it did not seem to be inherently embedded within them, like a disease (Madigan, 2015, 2019). For instance, a person could call their depression "the black box," where sad things are kept. Externalizing a problem also allows individuals to separate from their problem and focus keenly on finding solutions. In 1983, Michael and Cheryl founded the *Dulwich Centre for Narrative Therapy*, which has become the preeminent center for narrative therapy in the world (Chamberlain, n.d.; Madigan, 2015, 2019). After Michael stepped down as editor of ANZJFT, Cheryl created Dulwich Centre Publications. This eventually became the vehicle through which most of White's works were published.

During the early 1980s, White developed a deep friendship with *David Epston* (C. White, 2009), a Canadian-born émigré to New Zealand. Epston was trained as an anthropologist but, like White, eventually worked as a social worker. Describing themselves as "blood brothers," Epston (2008)

notes they became close colleagues and friends: "... we decided to make our ideas and practice common property and vowed that we would never become rivals. We did what we said we would do all these years up until he died" (p. 5).

Like White, Epston focused on working with children and adolescents, and he too was married to a feminist. Both saw a major part of their life roles as being politically active to change what they saw as the oppressive political systems that subjugated and brought chaos to many individuals, particularly those who were marginalized. Although they never did therapy together, they wrote books that were instrumental to the development of narrative therapy (cf. Epston & White, 1992; White & Epston, 1990). For his work, Epston has been given distinguished contribution awards to family therapy theory and practice from the *Australian and New Zealand Journal of Family Therapy* and the American Family Therapy Academy (Taos Institute, 2022). His work continues to be foundational in the field of narrative therapy.

As White evolved, so did his theory (Beels, 2009; Epston, 2016). In the mid-1980s and on, White became particularly interested in the social construction of reality and how individuals develop their meaning-making systems. From the late 1980s, White became interested in *postmodernism*, which challenges many of the assumptions of *modernism*, the lens through which many scientists and theorists from a wide variety of disciplines had come to view reality. Postmodernists believe there are multiple ways to understand the world, no foundational rules defining who we are, and no one method of communication that would guarantee a better understanding of another person. Questioning truth, wondering how truth reverberates in society, and exploring how clients create reality as a function of such truths are some of the issues focused upon by the postmodern, narrative therapist. It is not surprising that during this time, White was influenced by the work of the French philosopher *Michel Foucault*, who spoke of how language is subtly created and used by the privileged to support their understanding of what is truth and that such truth maintains the roles of the privileged and often results in the oppression of others (Hahs & Colic, 2010; White, 2002).

White's interest in postmodernism soon brought him in close contact with *social constructionism*, or how values transmitted through language by the social milieu (e.g., family, culture, and society) are intimately connected with the development of the person. Such an approach suggests that the person is constantly changing with the ebb and flow of the influences of significant others, culture, and society. Ultimately, principles inherent in postmodernism and social constructionism became foundational to narrative therapy, and the approach took a keen interest in understanding how power affects all of us in subtle but pervasive ways by dictating the kinds of "truths" we come to hold and the narratives we create (see Box 11.1). Therefore, one of the functions of the narrative therapist becomes trying to understand clients' *dominant narratives* (or stories) and assisting clients in making choices about establishing counternarratives to live a more satisfying life.

BOX 11.1 "Good" and "Bad" English?

Language, power, and truth are intimately related. For instance, most of us have been brought up with the belief that a certain type of spoken English reflects the "correct" way to speak and is an indication of level of intelligence and social status. Barack Obama's former minister, Reverend Jeremiah Wright, highlighted this by noting that when President Kennedy would use uncommon English (which he did quite frequently), he would not be criticized, but if a Black child used uncommon English, they would be said to be using "bad English" (Wright, 2008, para. 30). In fact, when minorities use uncommon English, they are often said to be lazy, stupid, or rebellious, when in fact this is the language they have come to "know" within their own social milieu. Such language is seen as "less than" by many White Americans because it does not reflect the dominant language in the United States and is not used by those in power.

From a postmodernism and social constructionism perspective, differences among people are seen as a reflection of the transmission of dominant values and beliefs through language and not as some inherent pathological state of being that dwells within any single person or group. It is, therefore, not surprising that White, and his fellow narrative therapists, spent much time visiting other countries and cultures and helping those who were oppressed and disadvantaged, such as lower income individuals; women; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals; and others who are traditionally marginalized. For instance, White applied his theory to his work with Indigenous Australian people in New South Wales, Australia (Chamberlain, n.d.). Greatly influenced by the anthropologist *Barbara Myerhoff*, who studied the stories of a group of older and frail Jewish immigrants in California (Myerhoff, 2007), White found that by listening to the stories of the Indigenous Australia People's dispossession and relocation, he could help them create new stories that reframed their understanding of these horrendous events (Winslade, personal communication, May 6, 2008; see Box 11.2).

BOX 11.2 Retelling Stories to Make One Stronger

The following paragraph shows how stories, such as those of the Indigenous Australian People, can be retold in ways that make them stronger. Look in particular at how "Grief" has been externalized as these indigenous people retell their story:

> As Indigenous people of this country, we have faced so many losses due to past and present injustice. Grief's presence has been with us for a long time. Now we are seeking ways of speaking about Grief that are consistent with our cultural ways of doing things. We are remembering those who have died, we are honouring Indigenous spiritual ways, and we are finding ways of grieving that bring us together. We are telling our stories in ways that make us stronger. (Wingard & Lester, 2001, p. vii)

Ultimately, the narrative approach that White helped to establish has clients examine and understand their narratives, deconstruct their embedded stories, and create new narratives. One of the ways he did this was by encouraging clients to *externalize the problem* to separate them from the problem and see it more clearly. Along these lines, White often stated, *The person is not the problem; the problem is the problem* and would communicate with clients in a way that would assist them in *re-authoring* their narratives to achieve a new sense of who they are and develop increased satisfaction in life (Hart, 1995). His innovative ideas and work with children and families was one of the reasons he won the Distinguished Contribution to Family Therapy and Theory and Practice award from the American Family Therapy Academy in 1999 (White, 2007).

White had some help in the development and dissemination of narrative therapy. Of course, there was *David Epston*, his friend and colleague. In addition, *Karl Tomm*, director of the family therapy program at the University of Calgary, mentored and encouraged White, as he saw in the young Australian an original therapist whose ideas were worthy of a hearing. Tomm helped to open doors of international teaching for White and remained a friend to both Cheryl and Michael. Others, like *John Winslade* and *Gerald Monk*, have continued the narrative tradition. And, of course, White had his wife and David Epston, who also helped and encouraged him along the way.

In 2008, White published *Maps of Narrative Practice*. At around this time, Michael and Cheryl separated. Then, in January of 2008, White set up the Adelaide Narrative Therapy Centre, later to be called *Narrative Practices Adelaide* (Re-Authoring Teaching, 2010–2022) because he wanted to focus more keenly on his work, particularly family therapy, while Cheryl decided to continue her social justice and community work at the Dulwich Centre (Chamberlain, personal communication, May 14, 2008). His own best advocate for his approach, White could often be found traveling

the world presenting case histories and lectures on narrative therapy. It was on such a sojourn to San Diego that he died of a heart attack in April of 2008. A book of his unpublished papers, *Narrative Practice: Continuing the Conversations*, was published posthumously in 2011.

BOX 11.3 Want to Meet Michael White?

Want to hear a brief biography about White from the man himself and find other tidbits of information about him? Go to https://silver.odu.edu/psyadm/ to see a caricature of White talking about himself and his theory. Click on the postmodern door, and go into White's office.

View of Human Nature

> In the traditional scientific framework, truth is discovered, and in the postmodernist framework, truth is constructed. (Shapiro, 2015, p. 610)

From a narrative perspective, there is no one view of human nature; there are views of human nature. This reflects the *postmodern* and *social constructionist* perspective that individuals create their unique realities through interactions or discourses within their social circles (Combs & Freedman, 2012; Madigan, 2019). This point of view also implies that values held by powerholders in society tend to become the norms by which individuals compare themselves, and such norms are reinforced through the language that we share. For instance, psychiatrists and other mental health professionals who hold positions of power created a diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM*-5), and then most professionals began to "speak" its language. It became the discourse of a particular professional community. Over time, it had become the norm that professionals, and even most laypersons, consider when deciding whether one has what is called a "mental disorder." Ultimately, the *DSM* is reflective of the values of the powerholders who created it, and its worth, say the narrative therapists, should be looked at with that in mind.

From the narrative point of view, individuals are constantly in discourse with others within their social milieu, and it is through such interactions that they develop their sense of selves (i.e., we all have many selves), although a dominant self is usually focused upon by each person and by mental health professionals when treating a person (Madigan, 2015, 2019). Although people are deeply affected by the language used in their social spheres, narrative therapy is *antideterministic* because it assumes people can come to understand the realities they have created, deconstruct their foundations (take them apart), and develop or re-author new stories that are empowering. Thus, individuals can come to understand their dominant self but also begin to see other selves that can emerge and become increasingly meaningful in their lives.

Narrative therapy is a *positive*, *strength-based*, *future-oriented*, and *anti-objectivist* approach, which eschews any therapeutic model that tries to "reduce a person's identity to a solitary, unified pathological definition" (Madigan, 2015, p. 1052; Rice, 2015). Objectivists tend to believe they hold the truth and are the experts, as they diagnose individuals from a distance; focus on their past; find justifications for them to be ill, diagnosable, or unworthy in some manner; and ignore other understandings or interpretations of an individual's life.

Freedman and Combs (1996) offer a further understanding of the narrative approach by proposing a view of human nature based on four premises: realities are socially constructed, realities are constituted through language, realities are organized and maintained through narrative, and there are no essential truths.

Realities Are Socially Constructed

The narrative therapist believes that the psychological makeup of the person—that is, beliefs, values, customs, habits, personality style, and so forth—is created from the ongoing interaction

and discourse individuals have with their families and the larger cultural "soup" from which they come (e.g., ethnic group, community, and society). The dominant culture subtly, but powerfully, pressures diverse and marginalized individuals into adopting its truth, while subcultures develop alternative truths. Each group's truth tends to have categories of what is good, mediocre, or bad. Thus, if one does not fit into the dominant culture's understanding of reality, that person is negatively labeled in some fashion. This is why narrative therapists question the value of many Western-based counseling approaches, used by the vast majority of mental health professionals, who assume they have found some corner on the truth.

Realities Are Constituted Through Language

Narrative therapists believe that as individuals become increasingly networked within their social milieu, they develop a particular reality, or point of view, as a function of the language used within that milieu. Examples of how language creates reality are many. For instance, consider how the use of nonsexist language has changed our perceptions of what is real. Today, instead of "men working," we say "people working;" and instead of "stewardess," we say "flight attendant." And even more recently, we are beginning to replace the nouns "he" or "she" with "they," as we recognize the complexities of gender identity. Now, consider how the picture in one's mind of a work crew on a highway might change because signs now say "people working" instead of "men working."

Because language is closely related to what we come to perceive and to know, one's psychological style is seen as a pliable product of the language used in one's social milieu, not as something inherent within the person. And since context can change, individuals can change or even have multiple styles or identities, depending on the context in which they find themselves. Consequently, the therapeutic environment can offer a new context in which new realities can potentially be created for the client and the therapist, as they dialogue with one another.

Realities Are Organized and Maintained Through Narrative

The narrative therapist views reality as a creation of the individual's discourse with others and a function of the language used in those conversations. The resulting stories people create about themselves then maintain their reality. In addition, the cultural context from which one comes has dominant stories that are often integrated by the person and become a part of the life story of the individual. So to understand a person, listen to their stories. For instance, many Jewish people have heard the words "never again" as part of the story related to the Holocaust and other oppressive experiences over the generations. Certain Jewish holidays acknowledge these experiences, encourage memories of them, and honor the ability of the Jewish people to free themselves from the oppressors, while also stating that all peoples should be free. Consider how this dominant narrative may have affected a Jewish person's ways of knowing the world, with vigilance about oppression and mistrust of authority being woven into Jewish culture. Narrative therapy suggests that, like reading a good novel, one should "read" or listen to the client's stories and join the client in trying to understand their dominant stories.

There Are No Essential Truths

Rejecting the notion of an external truth, narrative therapists believe our realities are the products of discourses in our unique, contained world. Although we all tend to have dominant stories that dominate our lives and define the reality we live most of the time, we also have other stories that play a lesser role in our lives. In essence, we are *multistoried*. Our stories define who we are,

and reality or truth can change as a function of the particular story with which one is identifying in the moment. For instance, consider the different dominant stories of most Black and White people regarding the Black Lives Matter movement. Relative to the police, stories of many Black Americans have to do with oppression, police bias, and racist acts being carried out against them, while White Americans mostly have stories around the police upholding the law, fighting against injustices, and protecting citizens. Is it any wonder that many Black and White people view this movement through different lenses?

Because we are all multistoried, by listening to clients' nondominant stories and by helping them create new stories, counseling can help new realities emerge. Consider the implications this has for those who have been called "mentally ill." If when listening to a person's stories, one finds some contexts and times in which the person is not "mentally ill," is this person really "mentally ill?" This way of viewing mental illness contrasts sharply with the traditional view, which assumes there is something permanent and fixed within the person that makes them mentally ill (all the time). The narrative therapist believes that, through dialogue and by adopting different language, a formerly "mentally ill" person can identify a new, *preferred story* and can begin to identify themself as mentally healthy.

Key Concepts

Some of the key concepts that underlie narrative therapy include postmodernism, post-structuralism, social constructionism, narratives, dominant and problem-saturated stories, deconstruction, thin or thick descriptions, relativism, power, unique outcomes, re-authoring, and lack of neutrality.

Postmodernism

In the movie *Sleeper*, the main character is placed in a cryogenic apparatus and wakes up in the future only to find that much of what used to be bad for him is now good:

> *Dr. Melik*: You mean [in the past] there was no deep fat? No steak or cream pies or hot fudge?
>
> *Dr. Agon*: Yes, but these things were considered unhealthy. Precisely the opposite of what we now know to be true. (Allen & Brickman, 1973, p. 20)

Like in the movie *Sleeper*, *postmodernism* suggests that what we come to know as truth can and likely will change as a function of the context in which we find ourselves. Postmodernism suggests that *modernism*, which had at its basis a belief that progress could be made through analysis, experimentation, and scientific knowledge, needs to be questioned. It does not necessarily mean that what has been learned or discovered is "wrong" but that it is important to question how "truth" became known and what it means that we now have this new knowledge. In fact, by some, postmodernism is defined as the questioning of modernism, particularly such ideas as empiricism and that the scientific method can find "the truth" (Weinberg, 2008). The truths of science, the truth of a psychotherapeutic theory, and the belief that we can understand our existence are all questioned by postmodernists.

The postmodern revolution (well, uprising, at least) over the past 30 years has us questioning the foundation for our beliefs. Although we might all agree that an apple will fall "down" from a tree, there is much we can question; for instance, concepts such as Freud's psychosexual stages or Rogers's concept of the "congruent self" or the existentialist notion of choice all had meaning from within a certain context and time period. And even though they might, at times, offer us helpful models

for understanding self, they are all contingent on a certain way of understanding the world that is bound by the contexts from which they arose. Postmodernism, as understood through narrative therapy, suggests that our individual truths are reflected in our constantly changing narratives as our lives move on and our context changes (Madigan, 2019). And, they suggest, our individual truths are often reflective of the collective knowledge that has been transmitted through discourse with others. Thus, how we come to make meaning in the world is reflective of the larger system, which holds a certain view of truth, or epistemology.

Post-Structuralism

Considered part of the postmodern movement, *post-structuralism* is a reaction to *structuralism*, which was a concept closely aligned with the time period of the scientific revolution and later adopted by the social sciences and other disciplines (Combs & Freedman, 2012). In counseling and psychology, structuralism suggests the existence of inherent structures that affect personality development. The description of these structures is seen through a particular theory's view of human nature. Think of the "structures" that exist in psychoanalysis, person-centered counseling, or cognitive theory. Each of these theories has a particular belief about the development of our psychological selves and relies on certain structures that are believed to be present within the person. So beliefs about repression, self-actualization, or cognitive schemas are all structures that fit neatly into a larger system or theory that adherents to those theories believe molds how we come to know the world.

> The basic premise of structuralism is that all things have a structure below the level of meaning, and that this structure constitutes the reality of that thing. The vast majority of psychological practices are based on structuralism. (Madigan, 2019, p. 172)

The post-structuralists challenged this prevailing view. They disputed the notion that the psychodynamicists, existentialists, cognitive behaviorists, or other theorists held a monopoly on the truth about the nature of people. And they went a step further; they suggested that beliefs in these truths encourage a myopic way of knowing. Thus, individuals struggling to become less repressed, or more self-actualized, or to know their cognitive schemas become enveloped by these very processes, and these very processes end up dictating how these individuals come to understand the world. They do not see other ways of knowing as possibilities. In fact, language in society tends to reinforce many "truths" from structural thinking, and those who do not accept these truths are often seen as psychotic, stupid, defensive, immoral, or rebellious. Think of the counseling-related words and phrases that now exist and that we take for granted from this structural revolution: unconscious, id, ego, repression, defensiveness, superego, internality, self-esteem, self-actualization, need hierarchy, inner drives, cognitive schemas, and on and on. If you don't believe in the meaning behind these words, you are seen as being outside of the norm—not in the mainstream—a nonbeliever.

A word of warning—post-structuralists are not saying these systems do not exist; they are saying we should view them as particular knowledge systems, or as one way of understanding the world (Combs & Freedman, 2012). And they are suggesting we take a look at what believing in any therapeutic system means for the person, their family, their culture, and society. In the end, post-structuralists have offered an alternative perspective that has a relativistic outlook—that is, a perspective that suggests there are many ways of knowing, none of which hold absolute truth, and all of which can impact the person in different ways (Marsten et al., 2016). Thus, post-structuralists do not label a person as *wrong* or *unhealthy*; instead, they suggest identities are constantly in formation as individuals interact with others over time.

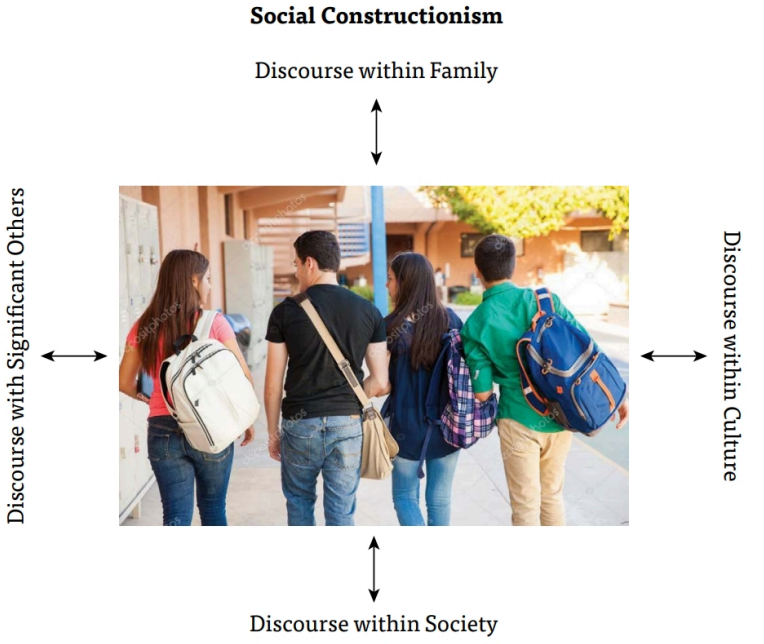
Social Constructionism

> The realities that each of us take for granted are the realities that our societies have surrounded us with since birth. The realities provide the beliefs, practices, words, and experiences from which we make up our lives, or as we say in post-modernist jargon, "constitute our selves." (Freedman & Combs, 1996, p. 16)

Social constructionism, which became prominent during the 1960s, suggests that knowledge is a function of the historical and cultural milieu from which the individual comes and that language and discourse shape mental concepts that become the basis for what is believed to be truth (Gergen, 2015; Richert, 2010; Winslade & Geroski, 2008). Thus, reality is an elusive, constantly changing concept that only exists among people, not within a person, and "truths" can be empowering for some but oppressive toward others.

With this in mind, there are many so-called truths relative to Western-based counseling theories that can be challenged, such as "We are the creators of our own fate," "We are individually responsible for what happens to us," and "If we dig deep enough, we can understand why we do certain things." Therefore, the humanist's concept of a self-actualizing tendency, the psychodynamic ideas about making the unconscious conscious, and the cognitive-behavioral beliefs about irrational or core beliefs all come into question. These concepts are seen as developed by a powerful elite of mostly White, Western males, who promulgated certain ideas within a mostly White mental health profession.

Rather than an "I can pick myself up by the bootstraps" attitude, the social constructionist says that as people interact with one another, they have ongoing conversations through which meaning is constructed and "I" is constantly changing (Combs & Freedman, 2016; Richert, 2010). Thus, identity is constantly in formation and changing as a function of the language that is used in interaction with others. In fact, from this perspective, one can have several "identities" or "selves," depending on the discourses one finds oneself in over time. I (Neukrug) am not one "Ed." Instead, I have an "Ed" with my partner, a different "Ed" with my colleagues, another "Ed" ("Dad") with my children, and another "Ed" ("Eddie") with my siblings, and the Eds, the Dad, and the Eddie change over time. And my sense of self is not embedded within me; it is a changing and evolving self in relation to the various groups within which I find myself. And to take it one step further, the word "Ed" is not sufficient to define all of who "Ed" is (see Figure 11.2).



Through ongoing discourse within a person's social and cultural milieu, a person constructs his or her sense of self, which changes over time. The person's narratives reveal this changing sense of self.

FIGURE 11.2 Social Constructionism

Narratives

> [W]e live by the stories that we have about our lives ... [T]hese stories actually shape our lives, constitute our lives, and ... "embrace our lives." (White, 1995, p. 14)

Our *narratives* are the stories that define who we are, and we are continually engaged in "storying" during our lives. There are many narratives that "embrace" us along our paths in life, and our stories can and do change as we move along. In fact, narrative therapists like to say that our lives are *multistoried*—that is, there are many stories that define who we are, and sometimes, the stories contradict each other. Some stories are unhelpful in the lives of clients as they feed into oppressive narratives, while other stories can be helpful in that they are empowering (Brown, 2007; Mehl-Madrona, 2010). Understanding the many different stories that exist within a person as well as being able to identify stories that contradict and deny other stories is critical to the narrative therapist's work. For instance, a counselor can try to uncover other, more helpful stories that contradict a *problem-saturated story* that is overwhelming and causing problems in a person's life. Thus, it is often said that individuals can *re-story* or *re-author* their lives and highlight and develop a *preferred story* through the narrative therapy process.

Dominant and Problem-Saturated Stories

Although we are multistoried, our lives are often saturated by *dominant stories* to which we ascribe our identity (Rice, 2015). These stories are generally passed along to us by significant people in our lives, our culture, our community, and our society. They are entrusted to us in subtle ways, perhaps subtler than some of us would like to believe. Yet in other ways, they are obvious in that we can quickly identify them when we begin to look for them. Since many of the stories are representative of values or normative ways of being within the larger community or in society, many of us have similar stories to which we ascribe to our identity. And when we do not meet the normative way of being as suggested in the story, we sometimes believe there is something wrong with us. So we hear that "girls should be one way," and "boys should act a different way," and if we do not adhere to the ways that we have been "told" to act, there is something wrong with us. That is why so many people believe that a woman who acts assertively is "bitchy," but a man who acts assertively is "effective," and a man who is mild mannered is "gay," and a similarly behaved woman is "sensitive."

Dominant stories can be *problem-saturated* when they are causing pain, distress, and dysfunction. For instance, consider a boy who, when sometimes acting in a sensitive manner, becomes verbally abused by his father and is told he'd better act more like a "man." This boy may now carry those negative views of himself, which are passed on to him by his father through language. This young man sees his sensitive self as "wrong," and society does little to contradict that view when it defines male sensitivity as "gay" and implies that there is something wrong with being gay. Whether this man is gay may or may not be important. What is important is how the language and its associated values used by his father and in society become integrated into the boy's sense of who he is. In counseling, one step toward helping this young man is through what is called the deconstruction of the dominant, problem-saturated story.

Deconstruction

> [D]econstruction has to do with procedures that subvert taken-for-granted realities and practices; those so-called "truths" that are split off from the conditions and the context of their production, those disembodied ways of speaking that hide their biases and prejudices, and those familiar practices of self and of relationship that are subjugating of persons' lives. (White, 1991, p. 27)

Deconstruction is the process of taking apart a dominant story to understand the beliefs, values, ideas, or social discourses that have been supporting it. Stories are generally kept alive by values

and ideas within families, culture, and society and then internalized by the client (Lukow & Goodwin, 2015). It is usually important to help the client understand how the story was developed, so they can see the relationship between the story that has been internalized and the broader social milieu that "handed" the story over to them.

> From this perspective, it is proposed that persons' lives are shaped by the meaning that they ascribe to their experience, by their situation in social structures, and by the language practices and cultural practices of self and of relationship that these lives are recruited into. (White, 1991, p. 27)

As the narrative therapist listens to the dominant story with a different ear than the client's, the therapist hears the "gaps" in the stories and realizes that other stories intertwine, parallel, and even contradict the dominant story (Madigan, 2019). Through a combination of listening and asking *questions*, the narrative therapist evokes other stories that have been in the background in the client's life—stories that deny, contradict, and oppose the dominant story. And as the narrative therapist begins to have some ideas about how the dominant story took on so much power to begin with, the therapist might raise questions to the client about them, while being respectfully curious. As this process proceeds, the strength of the dominant story lessens because it is being "deconstructed," or taken apart slowly and seen in a new light.

Thin or Thick Descriptions

> It is almost as if we are born with an inconclusion, and until we fill the gap with story, we are not entirely sure, not only what our lives mean, not only what secrets require our attention, but that we are there at all. (Myerhoff, 2007, p. 18)

Our understanding of ourselves is often based on what is called a *thin description* of our life stories (Lukow & Godwin, 2015). Such descriptions, which generally evolve out of our problem-saturated stories, leave little room for alternative explanations, lend themselves toward narrow explanations of events, and tend to "dominate" the way we come to understand who we are. *Thick descriptions*, on the other hand, are complex descriptions of our lives and the stories that describe our lives, and an understanding that our lives are multistoried. In narrative therapy, the therapist hopes to examine alternative stories that deny or contradict the dominant, thin stories, which are often problem-saturated. For instance, the "sensitive" man discussed earlier initially focuses mostly on his abusive father's comments about him, which leads to his "thin" conclusion about who he is. By helping the client identify other memories that contradict the dominant, problem-saturated story, the client can begin to develop a more complex and richer story about self that includes multiple aspects of self.

Relativism

> We are moving towards a dictatorship of relativism which does not recognize anything as for certain and which has as its highest goal one's own ego and one's own desires. (Pope Benedict XVI, 2005 as cited in Wiker, 2013, para. 1)

Relativism is the idea that truth, morality, and knowledge can only be understood from within its cultural and historical context and is not absolute (Skovlund, 2011). Thus, truth is relative, or simply put, there are multiple truths that all hold meaning. You can see why, in the above quote, Pope Benedict, who believes there are some ultimate truths, would think that relativism could present havoc for society. Narrative therapists, in contrast, suggest that truth is seen from the

perspective of the discourse from which the individual emerges and that an individual's sense of the world tends to be dominated by one or two stories, which have become the client's basis for truth. These dominant stories are generally linked to cultural imperatives (e.g., family, community, religion, and society) and result in the oppression of certain groups of individuals. Narrative therapists help individuals look at how they have been negatively and positively impacted by the language of their cultural milieu and of the society in which they have been immersed (Lukow & Godwin, 2015).

The narrative therapist also suggests that, despite being dominated by one or two stories, we all have multiple stories that contain multiple truths, and they help clients examine how their dominant stories may have affected themselves and others. Thus, the narrative therapist often has conversations with the client about other "background" stories in the client's life. In this manner, the narrative therapist can help the client examine the impact of the dominant stories and can engage in discourses with the client about what other "storylines" they may choose to live in their lives. In that sense, they can now begin to "re-author" their lives.

Power

The narrative therapist's ideas concerning relativism are closely associated with issues of *power* and inequities in society, as dominant societal "truths," which many of us end up believing in, are just one take on the truth (Combs & Freedman, 2012; Guilfoyle, 2014). And it is these same truths that tend to maintain the power structure in society and result in the oppression of nondominant groups. For the narrative therapist, dominant stories from society are internalized by individuals, cause people to live out and believe stories that tend to oppress the underclass, and blind clients to other possible stories and opportunities. Thus, stories about how certain clients of color are "lazy," "stupid," "rebellious," and so on are often subtly, and sometimes blatantly, passed down. They become part of the dominant stories of those in power and are even sometimes internalized and "believed" by the very people whom the stories are about. Since those in power are often unaware of their privileged position, it is also helpful for them to examine the stories they have developed in their own lives. Enlightening those in power to their narratives can help them see how their story is one that has been used to oppress others. You can see why narrative therapists are particularly sensitive to how oppressed groups are treated and how that treatment becomes part of the individual's sense of identity.

Unique Outcomes (Sparkling Outcomes and Exceptions)

Helping clients identify times that deny, contradict, or modify the dominant, problem-saturated story is one of the major roles of the narrative therapist (Payne, 2006; Rice, 2015). The counselor does this by asking the client when in their life there were *unique outcomes* (sometimes called *sparkling outcomes* or *exceptions*) to the narrative that is "dominating" the client's life (White & Epston, 1990). Then, through respectful inquiry, the therapist explores and invites the client to magnify those unique outcomes. This process invites the client to develop new strands, or new stories, based on those unique outcomes or exceptions.

Re-authoring

> Re-authoring conversations invite people to continue to develop and tell stories about their lives, but they also help people to include some of the more neglected but potentially significant events and experiences that are "out of phase" with their dominant storylines. (White, 2007, p. 61)

As clients tell their life stories and reveal their dominant, problem-saturated stories that are filled with thin descriptions of who they are, they also provide small glimpses of other stories that contradict the dominant, thinly descriptive story (Rice, 2015). As the therapist hears these unique outcomes or exceptions to the dominant story, questions are used to focus upon how these unique outcomes or exceptions might yield alternative stories that lead to new conclusions about the client. As these unique outcomes and exceptions get pieced together into other stories, the client sees themself as a much more complex person who is not simply defined by the dominant, thinly descriptive story. At this point, the client can begin to develop alternative or *preferred stories* (Combs & Freedman, 2012). For instance, look at Figure 11.3, which shows the problem-saturated story, as well as two new alternative stories being generated by the "sensitive" man. As with the client illustrated in Figure 11.3, awareness of new but already existing parts of self through the new stories that have been identified helps clients *re-author* their lives as they increasingly redefine themselves in broader, more complex ways.

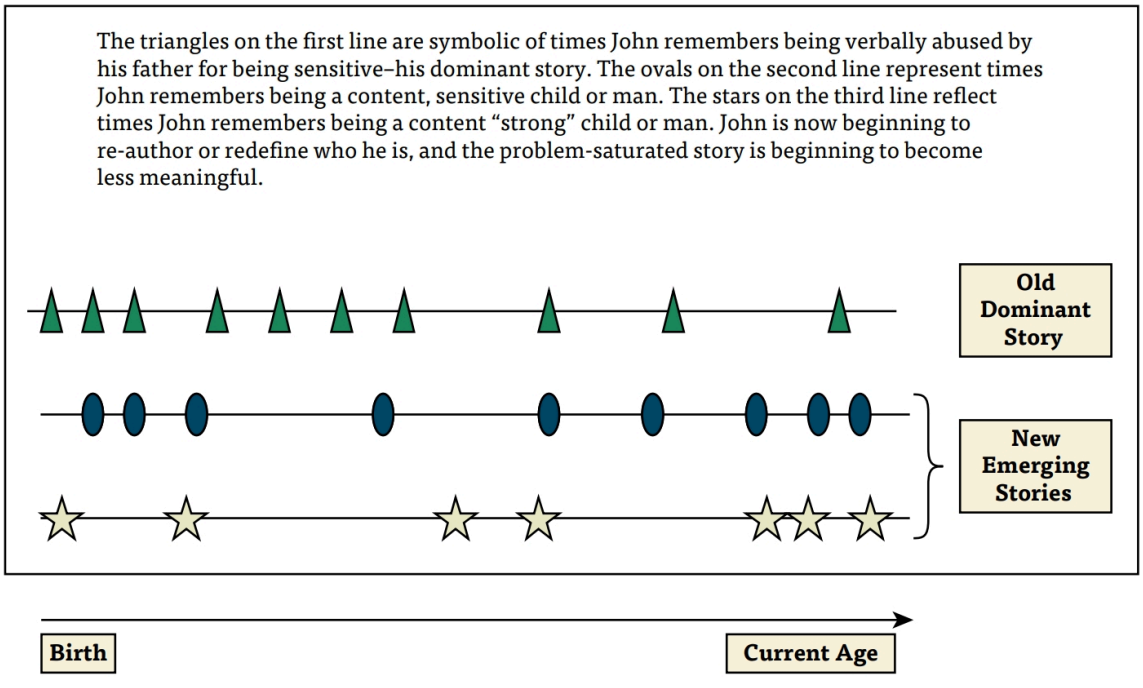


FIGURE 11.3 Identification of New, Alternative Stories

Lack of Neutrality

> [T]here is no neutrality on the part of therapists. Every response you take comes from a particular point of view. In fact, the assumption of neutrality is likely reinforcing the gender and cultural biases inherent in society. (White et al., 1994)

Narrative therapists believe we are never neutral (Winslade & Geroski, 2008). This *lack of neutrality* assumes that all of what we have been taught has been embedded into our ways of knowing and becomes the lens from which we see the world. So whether it is our knowledge about a counseling theory or a belief about cultural identity, our understanding of others is filtered through such beliefs, shapes our conversations with others, and affects our work in ways we sometimes may not be aware. Thus, given that we are not neutral, it is important to

consider how our biases shape our conversations with our clients. Perhaps more importantly, narrative therapists suggest that neutrality allows "isms," which are pervasive in society, to affect the client's life. Therefore, one role of the narrative therapist is to be nonneutral and to carefully suggest, or wonder with the client, what roles certain "isms" may have played in the development of the client's stories.

Therapeutic Techniques

Narrative therapy uses a wide variety of techniques to help clients understand and re-author their narratives. Some of these include showing mystery, respectful curiosity, and awe; use of questions; collaboration and reflexivity; reflection, empathy, and verbatim responses; encouraging clients to tell their stories; externalizing the problem and mapping its effects; having clients identify unique outcomes or exceptions; absent but implicit listening and double listening; considering social and political issues; scaffolding; using therapeutic documents and other paraphernalia; re-membering; definitional ceremonies; reflective teams; and telling and retelling.

Showing Mystery, Respectful Curiosity, and Awe

Narrative therapists enter the helping relationship with a sense of *mystery*, *respectful curiosity*, and *awe* as they position themselves toward hearing the client's story (Payne, 2006). They honor and respect the client, avoid labels, and do not view clients from a pathological perspective.

Strengths are highlighted as counselors present themselves more as *allies and equal partners* with their clients, although they are always aware of the power dynamics (Rice, 2015; Harrison, 2013). They assume clients have the tools and ability to assist themselves in reducing their own problems and do not find fault with the client for their situation (Morgan, 2000). This role helps to demystify the relationship and to define it as a discourse between individuals in which both can change. The use of specific questions that foster this kind of relationship are particularly important here (see Use of Questions).

Use of Questions

> [I]n a therapy of oral tradition, the re-authoring of lives and relationships is achieved primarily, although not exclusively, through a process of questioning. (White & Epston, 1990, p. 17)

The *use of questions* is one of the most critical tools for the narrative therapist, as questions help set the tone for the direction the relationship will take (Combs & Freedman, 2012; Rice, 2015). Questions near the beginning of the relationship will reflect respectful curiosity, mystery, and awe about the client's reason for coming to counseling and serve to encourage the client to discuss their problem-saturated story. As the relationship continues, questions will focus on externalizing the problem and on mapping its effects. Then, the focus of questions becomes an exploration of unique outcomes or exceptions to the client's problem-saturated story. Later, questions will focus on how the client might be able to re-author their story. Table 11.1 offers some typical kinds of questions that might be asked at different points in the therapeutic relationship.

TABLE 11.1. Sampling of Types of Questions Used in Therapeutic Relationship

Time of Relationship	Focus of Questions	Type of Question
Beginning	Respectful curiosity, mystery, and awe	• Can you tell me what brings you here today? • How did you come to have this problem? • How do you think this problem has affected you? • I'm interested in knowing as much detail about your problem as possible; can you explain it to me? • What about that problem is so powerful for you? • That is really interesting; can you tell me more about how this happened to you? • I'm wondering how this problem got so big for you. • How do you think the problem has affected you? • Do you like what the problem has been doing, or do you object to it? Why?
Late beginning	Externalizing the problem and mapping the effects of the problem	• How did this problem enter your life? • If we were to give a name to this problem, what do you think that might be? (e.g., "the black box") • What is it about ["the black box"] that you object to? • How has ["the black box"] altered your life? • How does ["the black box"] affect your life? • What do you think the implications for ["the black box"] are for your life? • What would your world look like without ["the black box"]? • Any thoughts about how you might tackle ["the black box"]? • If you had any means at your disposal what would you do to rid yourself of ["the black box"]?
Middle	Unique outcomes or exceptions	• What would you prefer? • If you were to not have this problem, how would your life look? • Have there been any times in your life when you did not have this problem? • What was so unique about the times you did not seem so affected by the problem? • It's amazing how much of your life was taken up by the problem, yet I think I hear there were times when that was not the case. Can you tell me about those times? • What was happening in your life during the times when you did not have this problem?
Late	Re-authoring	• Now that we've identified a series of times when you were free of this problem, do you have any ideas how you can make this happen in the future? • What name would you give to this counter-story? • How can we expand these other unique and positive times in your life and minimize these problem-saturated times? • How might you be able to expand these other storylines you've shared with me? • What would your life look like if it were dominated by these other stories rather than [the name of the problem]?

Collaboration and Reflexivity

In an effort to lessen the power differential between the client and the counselor, and to ensure that the direction of counseling is helpful for the client, counselors will often take steps to *check in* with the client (Rice, 2015). This type of *collaboration* is generally done by using specific questions. For instance, Morgan (2000) notes that the following questions may be asked at any point during the relationship:

- How is this conversation going for you?
- Should we keep talking about this, or would you be more interested in ... ?
- Is this interesting to you? Is this what we should spend our time talking about?
- I was wondering if you would be more interested in me asking you some more about this, or whether we should focus on X, Y, or Z? [X, Y, Z being other options] (pp. 3–4)

Along these lines, an explanation regarding what the therapist is doing will sometimes be given to the client as a way of making sure the client understands and feels comfortable with what is happening in counseling (White et al., 1994). In addition, using a process called *reflexivity*, the client is invited to comment on the helping process, so the helper can learn from the client the impact the helping process is having on the client. In this process, respect for the client's perspective on what is occurring in counseling is paramount (Besley & Edwards, 2005; Winslade, 2005).

Reflection, Empathy, and Verbatim Responses

Watch Michael White work with clients, and you will see a mixture of questions, reflections, and empathy as he attempts to connect, or *join*, with them as they explore their stories (White, 2012). Empathy in this context should not be viewed as a tool to try and understand what is "underneath" the problem but as an important technique that shows you have heard the client accurately. The use of *reflection* and *empathy* is a powerful tool that helps therapists connect with their clients, helps clients continue to talk about their stories, assists clients in deepening the level of trust, fosters the exploration of the clients' stories in new detail and in new ways, and helps to reinforce clients' development of new stories. Reflection and empathy are not neutral tools, as what counselors decide to reflect mirrors their own biases and beliefs (Freedman & Combs, 1996). In fact, many times, the therapist will use *verbatim responses* in an effort not to influence the client and to ensure the client clearly hears their own problem-saturated story. Accurate reflection, empathy, and verbatim responses, it is hoped, will assist clients in their re-authoring of new stories that are not problem-saturated.

Encouraging Clients to Tell Their Stories

Encouraging clients to tell their stories is one of the cornerstones of the narrative approach, since narrative therapists believe stories are the vehicle for understanding the complexity of the client's life (Wong, 2015). During the beginning phase of therapy, counselors should keep in mind that clients present a thin description of their stories; that is, they are generally not fully aware of the complexity of their problem-saturated story or that other stories may contradict or deny the problem-saturated story. In addition, early in therapy, much is omitted from clients' initial descriptions due to forgetfulness or feelings of mistrust and embarrassment about sharing intimate details. Thin descriptions of stories often lead clients to thin conclusions about their lives, as they tend to view the world in simple, often dualistic, ways (Morgan, 2000). As clients continue to tell their stories, the narrative therapist can help them expand on the problem-saturated stories. This is generally accomplished through the counselor's ability to be respectfully curious, show wonderment, and ask questions about their stories. Such therapist qualities tend to invite clients to describe

their stories more fully. Reflections, empathy, and verbatim responses can also be useful tools in understanding clients' stories and in encouraging them to describe their experience more fully.

Externalizing the Problem and Mapping Its Effects

Believing that the current state of mental health counseling tends to view problems as being something inherent or inside the person, White, and others (e.g., Combs & Freedman, 2012; Madigan, 2015, 2019), encourage counselors to assist clients in *externalizing the problem*—that is, making it something that is outside of the person. In fact, as noted earlier, on numerous occasions White suggested that, "The person is not the problem; the problem is the problem" (see Box 11.4). The counselor also helps the client *map the effects of the problem* by helping the client understand its multiple meanings, including how one's social milieu may have reinforced the belief that the problem is within the person and not a function of a problem-saturated story created through one's interactions with others. Redefining the problem in this manner helps the client develop novel solutions to the problem (White & Epston, 1990).

BOX 11.4. Beating Sneaky Poo

In a sometimes funny manner, Heins and Ritchie (1988) took ideas developed by Michael White and wrote a short book with illustrations, for children aged 5–10, that helps them deal with the serious issue of encopresis (fecal soiling). By externalizing the problem, "sneaky poo" becomes the focus of the concern that children, parents, and, sometimes, medical professionals work together to solve. By focusing on "sneaky poo," rather than the child, children stop experiencing the blame that often comes with encopresis, as they separate themselves from the problem. After externalizing the problem, the authors give hands-on ways children and their parents can help "sneaky poo" not be a problem any longer.

Unique Outcomes or Exceptions

As clients feel increasingly comfortable revealing their stories and using questions and discussion (see Use of Questions), they begin to examine key aspects of their lives that are not problem-saturated. Identifying times that seem to be at odds with, rebuff, or demonstrate a smaller impact of the problem-saturated story, these *unique outcomes*, or *exceptions* to their problems, help to reframe a client's sense of identity (Combs & Freedman, 2012; Rice, 2015). While some narrative therapists will specifically ask if there were times when the problem was not as prevalent or did not exist, others will wait for clients to generate times on their own when the problem was not dominating the client's life. Eventually, the counselor can help the client string together aspects of the client's life that are not problem-saturated, so they can embrace alternative stories.

Absent but Implicit Listening and Double Listening

> It is not possible to talk about anything without drawing out what it is not. Every expression of life is in relation to something else. (White, 2006, as cited in Carey et al., 2009, p. 319)

Absent but implicit listening is related to the notion that every experience and expression a person has in life has multiple layers, and some of which are obvious (explicit), while others are less obvious

but may be implied (Carey et al., 2009; White, 2000). Thus, the counselor has an opportunity not only to listen to the story that is being told but to *double listen*—that is, listen and inquire about the less obvious, implied story of the client (Combs & Freedman, 2012). This opens opportunities for clients to discover other meanings to their problem-saturated story, which can lead to other, thicker descriptions of their lives.

For instance, Preston, who initially came to counseling because he felt his anger was sometimes out of control, has externalized his problem as the "angry red monster." He described a series of incidents in which he felt like he or others were treated poorly and he "lost his cool." Just a few of these included the following:

- screaming on the phone at the person who works for the health insurance company because the company did not pay for a doctor's visit that he "knew" should be included in their coverage
- yelling at his wife for instances when he stated that his wife was spending an inordinate amount of time with their children and his in-laws
- walking out of a class he was taking in graduate school and yelling to the students and the professor "you're all a bunch of racists" during a discussion on multiculturalism
- becoming irate at a Dunkin' Donuts cashier for charging him "inappropriately"

As Preston continues to discuss the "angry red monster," the counselor asks Preston a series of questions that focuses on that which is absent but implicit, rather than the direct content being offered by him. In this sense, the counselor is double listening—listening to the content of what Preston has said but also listening to that which is absent but implicit.

Choosing to focus on the absent but implicit, the counselor might ask Preston a series of questions that can help develop new conversations about Preston's angry red monster. For instance, the counselor might ask, "What do you think your anger wants from you?" or "How do you imagine these situations would be best resolved?" or "What is it about each of these situations that are egging you on?" or "What would life be like if these situations didn't exist?" To these questions, Preston responds that he has always felt that life was filled with injustice. The therapist then invites Preston to discuss what injustice means to him and to relay any stories in his life that may have to do with injustice. Preston quickly describes a series of stories about the importance of fighting injustice. Being Black and growing up in the South, Preston talks about several discussions, when he was young, concerning injustice done to their "people." He remembers "endless" conversations with his grandfather about segregation and describes how his grandfather had to "kowtow" to the "White man." He goes on to talk about how his family and extended culture stressed the importance of fairness and justice. He notes that he married a woman who was an "activist," who fought injustice. He then notes, "Most of my adult life I have been fighting injustice—it just makes me so angry." As Preston says this, he suddenly blurts out, "I take injustices very seriously, whether it is to others or to me. I guess I see how my life has been filled with themes that involve injustice. I see how I have been treated unjustly, and I also see how some of my reactions have been unjust to others."

Preston is examining his dominant, problem-saturated story and is beginning to see how his life is multistoried and much more complex than he originally viewed it when first describing his anger. He can now find other ways of elevating other, unique stories in his life, while limiting his problem-saturated story, if he so chooses.

Considering Social and Political Issues

Narrative therapists believe there are a wide range of social and cultural issues that affect an individual's experiences. However, because the Western world has a legacy of viewing problems from an intrapsychic perspective, such issues often get hidden as individuals blame themselves for

predicaments that may be partly or fully outside of their control. Narrative therapy helps a person identify issues of sexism, racism, classism, heterosexism, and elitism as well as other ways in which individuals have problems created for them due to abuses of power (Combs & Freedman, 2012). Usually, sometime after the client has begun to externalize the problem, narrative therapists will use questions to help clients *consider how social and political issues* have shaped their dominant, problem-saturated stories (White et al., 1994). A small sampling of such questions might include the following:

- Can you describe times when you have been discriminated against?
- How do you think gender roles have affected your relationship with your spouse (or lover) or others?
- Do you think there are any societal values that work against you living a more peaceful and loving life?
- Do you think that issues of race may have been responsible for you not being promoted at work?

Scaffolding

> [S]caffolding provides people with support in the incremental and progressive distancing from the known and familiar toward what it is possible for them to know and to do. (White, 2012, p. 123)

Moving from a dominant, problem-saturated story to a new way of seeing self is one of the major goals of narrative therapy. This process takes time and occurs by identifying unique outcomes and exceptions, building on past strengths, and looking toward the future, as the client is *scaffolding* toward a new understanding of self. By weaving together events not linked to the problem-saturated story, the client slowly builds new stories. Although the problem-saturated story still exists, it begins to take on different meaning and a smaller role, as the client builds new, more positive stories. Slowly, the client begins to view themself through a new lens that is jointly developed through collaboration with the therapist.

In explaining this process, White (2007, 2012) talked about the importance of developing tasks for the client that slowly distances them from the problem-saturated story. Over time, White suggests that clients can move from *low-level distancing tasks* to *high-level distancing tasks*. Thus, the woman who has a story that she is worthless and not deserving of love might be asked to consider a time when this was not the case and to share that memory. Finding exceptions to their problem-saturated story would be the beginning of a new story and a low-level distancing task. Contrast this with the woman who now sees that she is deserving of love, and the counselor dialogues with her about various ways in which she can find loving relationships in her life. The counselor then suggests a high-level task, such as a ceremony in which loving friends are brought in to share their thoughts with her, thus building on her newfound "loving" identity.

Use of Therapeutic Documents and Other Paraphernalia

To acknowledge progress and describe change, *therapeutic documents and other paraphernalia* are often encouraged or provided (Payne, 2006). For instance, clients might journal about how they now view their lives as compared to how their lives were when the problem dominated their lives, or they might write biographies that show the shifting changes in their lives. Therapists can also use documents to show client progress, such as writing letters to clients that affirm their changes, providing medallions that acknowledge shifts in thinking, or giving certificates that acknowledge new ways in which clients now understand themselves (see Box 11.5).

BOX 11.5 Was the Wizard of Oz a Narrative Therapist?

> [A] heart is not judged by how much you love, but by how much you are loved by others.
> —The Wizard (Langley et al., 1939, p. 107)

The Wizard of Oz used documents and paraphernalia to acknowledge aspects of the Tin Man, Scarecrow, and Lion that they, themselves, did not focus upon. Each of these characters had their own problem-saturated story. The Tin Man saw himself living a heartless life, the Scarecrow thought he was brainless, and the Lion saw himself as a coward. Pointing out to each of these individuals times when they were not who they thought they were underscored the notion that they did not have to continue accenting their problem-saturated stories. And to accentuate the importance of their new identities, the Wizard gave each of them something important. To the Tin Man, he gave a large, red, heart-shaped clock that hung from a golden chain; the Scarecrow received a diploma, so he would always be reminded that he was smart; and to the Lion, he gave a medal signifying how brave he was.

Re-membering

A term coined by Barbara Myerhoff (1982), *re-membering* has to do with helping individuals reconstruct their identities by accenting and expanding on specific positive memories and by limiting problem-saturated memories (Combs & Freedman, 2012). Re-membering allows clients to call up powerful positive images from the past, connects clients to something going on in the present, and provides a road map for the future. For instance, a client might have a memory of a time they did something heroic. This image can be called on, focused upon, and used as a metaphor for who they are now and how they will act in the future. Clients may also re-member individuals who have had positive influences on their lives but have been lost due to death, changes in location, loss of contact over time, and so forth (Hedtke, 2016). Clients can re-member through many avenues, including journaling, writing stories, meditating or reflecting, viewing videos, and so forth. In addition to re-membering positive memories, clients can delimit memories that have had negative influences on their lives.

Definitional Ceremonies (Outsider Witness Groups)

The term *definitional ceremonies*, sometimes called *outsider witness groups*, was originated by Myerhoff's (1982, 1986) work with older Jewish people in California, as she watched them "reinvent themselves" at a community center (Combs & Freedman, 2012). In narrative therapy, such a ceremony generally occurs after a client has begun to develop new, thick stories that start to reshape the client's sense of self and involves the retelling and witnessing of the client's new stories. Generally, this retelling is to a group of carefully chosen friends, significant people in the client's life, or individuals who had previously sought consultation for a similar difficulty and have expressed a desire to assist others in the future. Such witnessing by the group reinforces and solidifies the client's sense that they are moving on.

During such a definitional ceremony, White (2007) warns against using traditional methods of responding and suggests that the witnesses not applaud, affirm, congratulate, or interpret the client's stories. Instead, the purpose of the witness is to have dialogue with the client around images that may have surfaced and emotions that were evoked within the listener. This will generally lead to a discourse between witnesses and the individual that helps to "thicken" and solidify stories of all involved.

Reflective Teams

Reflective teams are when individuals observe clients with their counselors and, later, share their thoughts about what they have observed and experienced with the client and the counselor (Combs & Freedman, 2012). Reflective teams can include significant others, therapists, or individuals who have experienced similar issues in their lives. Originally used as a family therapy technique by *Tom Andersen* (1987), and sometimes considered a type of definitional ceremony, reflective teams offer clients a mechanism to consider new ways of re-authoring their lives. White (1993, 1995) suggested reflective team discussions be structured in four parts during one interview:

- **part 1:** The reflective team quietly observes the client with the counselor from behind a one-way mirror, via a closed-circuit TV, or as they sit in the same room as the client and counselor.
- **part 2:** The reflective team members introduce themselves to the client and then switch places with the client and counselor. While the client and counselor observe, the reflective team participates in a discussion that focuses upon exceptions to the dominant stories of the client, highlighted by their sense of humility, wonderment, and mystery about the client's narrative. Then, the reflective team members discuss possible alternative stories they think could be a potential outgrowth of the exceptions they have heard.
- **part 3:** The reflective team again switches places with the counselor and client. Then, the counselor and client have an opportunity to jointly discuss any aspects of the reflective team's responses that seem meaningful and helpful. This process allows for possible new realizations about the client's life that could bring new potential actions.
- **part 4:** All participants join together and ask each other why certain ideas were discussed, certain questions were asked, and other questions were not asked. As this interview concludes, the client can inform the counselor and reflective teams of those ideas that seem most promising in the development of new narratives.

Telling and Retelling

Telling and retelling stories helps to identify events that were not previously highlighted, sometimes because they were not part of the dominant narrative (Denborough, 2014; Morgan, 2000). Such retelling of stories can help develop new narratives that are based on past events in a person's life. For instance, as a child, I (Neukrug) was sick with pericarditis, an inflammation of the lining around my heart. The first telling of my story might only highlight the suffering; however, with subsequent retellings I might focus on my resilience when I was ill, thus, leading to a possible new narrative that focuses on my strengths. Re-authoring, telling and retelling new stories can help reinforce the client's newfound sense of identity. This can be done through discourse with others; by writing letters or e-mails to self and others; by writing an autobiography; through creative outlets, such as drawings or sculpting; by making video recordings or writing blogs; by using outside witnesses; by having definitional ceremonies; and so forth.

The Counseling Process

The lack of belief in absolute truth suggests there is no absolute process of therapy. Therefore, it is unlikely that you would find narrative therapists identifying specific stages of therapy. However, based on the writings of several well-known narrative therapists, one can gain a general sense of the direction in which clients move in counseling (Madigan, 2019; Payne, 2007; White, 1993). Based on their ideas, we have generated *four broad phases* that most clients experience in the narrative therapy process:

- **joining:** This is when the therapist meets the client, begins to build a relationship, and invites the client to share their problem-saturated story.

- **examining patterns:** This is when the client is invited to examine stories that contradict, deny, or oppose the problem-saturated story.
- **re-authoring:** This is when the client begins to build new, more positive stories.
- **moving on:** This is when the client has developed a new, more positive outlook on life and is ready to leave therapy.

Figure 11.4 maps the likelihood of specific techniques being used within the phases. However, keep in mind that narrative therapy is a free-flowing process, in which phases can re-emerge, as the therapeutic process continues.

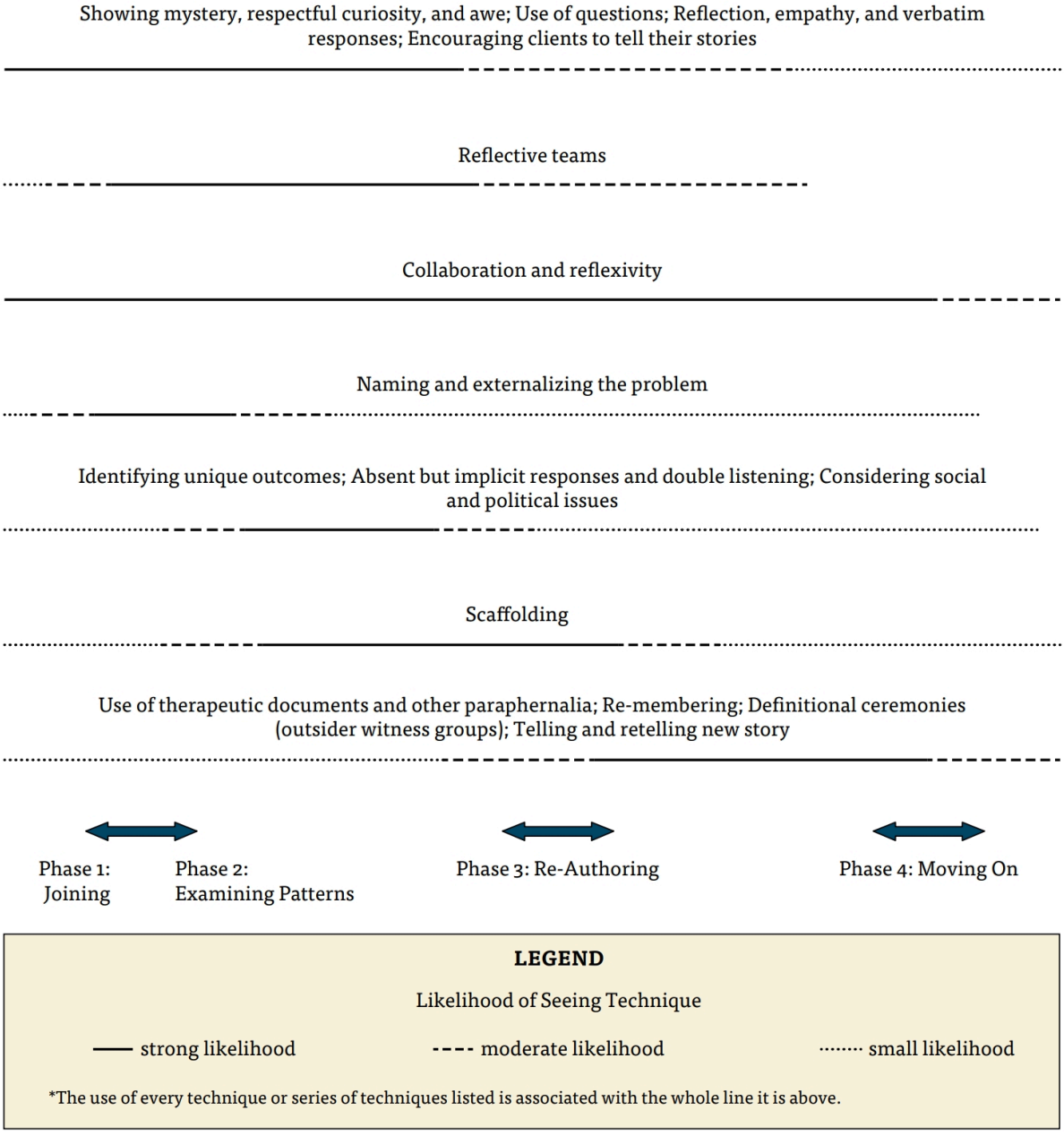


FIGURE 11.4 Likelihood of Techniques Occurring as a Function of Phase

Social, Cultural, and Spiritual Issues

> [T]he problems for which people seek therapy are the outcome of certain practices of relationship and practices of the self, many of which are actually informed by modern notions of "individualism" ... [and] are so often mired in the structures of inequality of our culture, including those pertaining to gender, race, ethnicity, class, economics, age, and so on. (White, 1995, p. 115)

As a postmodern approach, narrative therapy is well-positioned to support culturally responsive practice. The contexts in which we live are imbued with historical influences and contemporary experiences of cultural privilege, oppression, power, and subjugation and result in individuals who are multistoried. Counselors listen intently for power themes in stories and how social interactions influence self-concept and, thus, the stories clients tell about themselves.

This approach focuses on identifying, deconstructing, and re-authoring the dominant story to enhance the client's identity and values in a positive direction. The narrative therapist prioritizes cultural understanding by listening to the client's narrative and how the narrative shapes and is shaped by their cultural identity. Thus, the counselor remains curious and nonjudgmental about the client, the client's stories, and the power the stories hols. They attend to the client's cultural worldview by actively listening to their lived experiences described in the narrative, identifying the dominant story held by the client, externalizing the problem to separate from their identity, seeking exceptions to and identifying alternatives for the dominant narrative, supporting thick descriptions during telling and retelling of stories, and working to develop counternarratives or re-story those experience to support their identity and empower the client (Farrell & Gibbons, 2019; White, 2007).

Although narrative therapists do not push their values onto their clients, they are not "neutral" (Combs & Freedman, 2012; Farrell & Gibbons, 2019). In fact, narrative therapists believe that when counselors are "neutral," they are subtly supporting the "isms" of society. This stance lies in the belief that issues of power and subjugation occur in both obvious and subtle ways, are endemic throughout society, and are particularly harmful to clients from diverse backgrounds. Although they will not push their agendas onto clients, they will, in collaboration with the clients, ask questions that might raise issues about privilege, oppression, and power.

From a cross-cultural perspective, clients may hold multiple dominant stories, each based in a particular identity. In addition, the way these stories are told vary based on culture (e.g., chronologically, thematically, and through the use of metaphors). The counselor helps to deconstruct the dominant story or stories to support the intersection of clients' multiple identities. For example, Farrell and Gibbons (2019) applied narrative therapy to a case of a Latino immigrant college student. The client's identities (e.g., Latino, college student, and immigrant) each held powerful narratives, and the counselor worked with the client to embrace their multiple experiences and intersectional identities to re-story their narrative and, thus, address the presenting problem (i.e., academic difficulties and poor class attendance).

The narrative therapist's role is that of an advocate, which is imperative for dismantling the effects of dominant stories that are particularly harmful to marginalized groups in society. If you believe that language creates reality and sometimes results in the overt and covert oppression of certain groups, there is no other choice but to advocate for those who are oppressed and to recognize the advantages of those who are privileged (Patrick & Connolly, 2013).

Spirituality as a part of clients' cultural identity can be a powerful component of the stories they tell. Although religion can be disempowering and abusive in the lives of some clients, there are other aspects of religion or spirituality that can be examined and uplifting for a client who may have been ignored. In fact, McVeigh (2016) suggests it is critical to develop conversations that will help clients find unique outcomes and alternate stories on their way to re-authoring their spiritual lives. Being able to disengage from old, oppressive stories and develop new, empowering stories that re-engage

a person in their religion, or in a newfound religion or spirituality, can be a goal of narrative therapy (Nelson-Becker, 2004; Nelson-Becker & Sangster, 2019). In the end, the narrative therapist does not see religion as holding exclusive truth, but it can be meaningful in defining how clients live their lives:

> We want to know the truth about reincarnation, we want proof of the survival of the soul, we listen to the assertion of clairvoyants and to the conclusions of psychical research, but we never ask, *never*, how to live. (Krishnamurti, 1969, p. 76)

Finally, the following highlights how narrative therapy is aligned with the four developmental domains of the *Multicultural and Social Justice Counseling Competencies* (*MSJCC*; Ratts et al., 2016). Here, we provide questions that counselors may consider when building their cultural competency, while further promoting the effective use of narrative therapy:

- **counselor self-awareness:** Counselors should be cognizant of their worldview and combination of privileged and oppressed statuses. They should be familiar with how their cultural identity plays out in their personal and professional experiences, and they should engage in culturally appropriate skill development to effectively communicate and apply their knowledge.
  - What are the dominant stories I hold about my cultural identities? Within these stories, where do I hold power?
  - Am I using labels and terminology from my own personal and professional experiences that can be disempowering to my client? Am I seeking their understanding of these labels?
  - What are the biases that I hold about my client's experiences based on my own worldview? To what extent do my biases impact my client's re-storying process?
- **client worldview:** Counselors should be aware and knowledgeable of the client's worldview, biases, cultural identities, and experiences with power, and they should enrich their skills and take actions that promote understanding of the client experience.
  - Am I careful to understand the language in my client's storytelling and how their language is based in their social, cultural, and/or spiritual experiences? What meanings or descriptors do they use about themselves and their experiences?
  - Am I leading my client to identify unique outcomes or exceptions within their problem-saturated stories that are counter to their worldview (e.g., individualistic versus collectivistic exceptions)?
  - Do I share with my client how privilege, oppression, and power may be a part of their problem-saturated story?
- **counseling relationship:** Counselors should be aware and knowledgeable regarding how the counselor and client's cultural identities and combination of privileged and oppressed statuses influence the therapeutic process. They should enrich their skills and take actions that promote a positive therapeutic alliance.
  - Am I remaining curious about my client's narrative without leading them too quickly to re-authoring?
  - Am I supporting dominant values during the therapeutic process (e.g., use of self-disclosure, overreliance on emotional processing, and adherence to traditional gender roles) that inadvertently hinder my client's functioning and ability to develop counternarratives?
  - At what point in the therapeutic process can I solicit input from the client on the therapeutic process and demonstrate that I am being reflective about such input and action-oriented regarding the input I receive?
- **counseling and advocacy interventions:** Counselors should be able to facilitate client advocacy or be advocates themselves at 6 levels—intrapersonal, interpersonal, institutional, community, public policy, and international.
  - To what extent am I assisting my client to externalize their problem to create a preferred story in which they have a greater sense of power over their problem?

- Am I highlighting how my client's cultural strengths can inform their counternarratives?
- Am I encouraging my client to consider multiple and systemic contexts as they consider unique outcomes or exceptions to their problem?
- Am I encouraging my client, and myself, to advocate for social injustices at multiple levels?

Efficacy of Narrative Therapy

Over the past two decades quantitative studies have demonstrated the effectiveness of narrative therapy in a number of cultural contexts and populations. For example, narrative therapy has:

- improved communication, marital commitment, and marital satisfaction and functioning (Chimpén-López et al., 2021; Ghavibazou et al., 2020; Taghiyar & Pahlavanzade, 2019);
- increased self-esteem and decreased stress response for individuals with alcohol dependency (Park & Kim, 2021);
- improved stress coping and lower depression and anxiety among children and adolescents (Cho & Kim, 2015; Choi & Lee, 2014; Ghorbani & Raeisi, 2020; Jalali et al., 2019; Vromans & Schweitzer, 2011);
- increased the development of children's social and emotional skills (Beaudoin et al., 2016);
- decreased youth smartphone addiction (Choi et al., 2017);
- alleviated ADHD symptoms among women and among children (Looyeh et al., 2012; Robinson et al., 2015);
- decreased disordered eating symptoms among youth (Weber et al., 2006); and
- improved career decision-making and career self-efficacy among high school students (Özer et al., 2021).

In addition to these studies, the Dulwich Centre for Narrative Therapy (n.d.) provides, on their website, an updated list of empirical evidence from the past two decades for narrative therapy.

Like other therapeutic approaches, additional quantitative studies that include randomized controlled trials, systematic reviews, and meta-analyses are needed. Furthermore, narrative therapy, with its focus on the client's subjective experience, is well-suited for study using qualitative approaches (see Table 11.2). As counselors engage in their practice, they can use client responses to the questions they pose as a source of qualitative data to inform the profession's understanding of how client narratives are socially constructed and, thus, embedded within their social, cultural, and spiritual contexts.

Narratology, or narrative analysis, is one of the prominent qualitative research traditions that can be readily applied to studying the efficacy of narrative therapy. It seeks to understand what stories or narratives reveal about an individual, and it assumes that stories are indicative of cultural and personal information that can potentially apply to a larger context and, thus, therapeutic practice with other clients. Co-constructed between storyteller and audience, narrative is not simply a story but an account of events, individuals, and processes that expresses how individuals make sense of their worlds (Clandinin et al., 2018). Hays and Singh (2023) identify the following assumptions about narratology:

- Individuals speak in narrative form, connecting events over time through stories that are constructed in a personally and often culturally meaningful manner.
- Individual identities are shaped by the stories they recount and share with others.
- Narratives change depending on the narrator, audience, and context.

Counselors engaged in narratology are interested in several features of the client story as they analyze data: the function of the story; how and why events are storied in the manner they are; what the story contents are; temporal order of the story; for whom the story is constructed; changes in the story expression based on audience; story consequences' cultural or other macrosystem components present in the story; and any gaps and inconsistencies that may warrant alternative or counternarratives (Clandinin et al., 2018; Hays & Singh, 2023). As you can see, these research techniques are congruent with several of the concepts and techniques of narrative therapy that were discussed in this chapter.

TABLE 11.2. Characteristics of Qualitative Research

Inductive and abductive analysis	*Inductive analysis* refers to the notion that data drives theory or a deeper understanding of an issue or phenomenon. As the research study progresses, patterns and themes are identified, and a phenomenon is understood more fully. *Abductive analysis* refers to researchers' immersion in and deliberate moving away from inductive and emerging deductive analysis to be open to new insights. It can support qualitative researchers to deeply engage in the data and avoid quick interpretation and theory development.
Naturalistic setting	Based on the assumption that clients interact with their environments to derive personal meaning, qualitative inquiry in a *naturalistic setting* affords counselors and researchers with opportunities to examine how individuals interact with their environment through symbols, social roles, and social and power structures, to name a few.
The importance of context	This is how participants create and give meaning to social experience. Phenomena are created and maintained by those in an environment, and social settings are self-organized and socially constructed. To this end, individuals in context interact with one another and patterns emerge that illustrate phenomena. The *importance of context* also includes the research context itself and is influenced by the research relationship.
The humanness of research	Counselors and researchers are subjective inquirers and an instrument of the study, and thus, there is a *humanness of research*, or Verstehen. This relates to researcher competence and researchers' impact on the design and participants—the nature of being studied and studying humans.
Purposive sampling	This refers to seeking information-rich cases that will best address a research question. The intention in *purposive sampling*, then, is to select participants for detail they can provide about a phenomenon and not to simply select participants to meet a certain sample size.
Thick description	This refers to providing details about the research process, participants, context, and participants to illustrate a phenomenon intensely and transfer knowledge to other settings (i.e., depth versus breadth). The end goal of *thick description* is to provide enough depth and detail that the reader can have enough information to generalize findings to a narrowed context or replicate the study in another setting.
Interactive, flexible research design	Components of qualitative research design are reactive to the ongoing research process. A design should interact with the environment, mutually influencing each other. An *interactive, flexible research design* includes five intersecting components: research goals, conceptual framework, research questions, methods, and validity.

Note. Adapted from: Danica G. Hays and Anneliese A. Singh, "Characteristics of Qualitative Research," *Qualitative Research in Education and Social Sciences.* Copyright © 2023 by Cognella, Inc.

The Millers

The following shows Celia going through narrative therapy. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Celia Meets With a Narrative Therapist

Outside her studio window the early fall light lay golden across the sill, unnoticed, as Angela's attention was absorbed by her canvas and paints. But Angela's serenity was disrupted by her phone. She eyed the telephone suspiciously. School had only started a week ago, and she had already had two calls from the school nurse. Though Celia seemed relaxed and happy over the summer, anxiety was now a problem for them again.

Angela recognized the school counselor's voice almost immediately. "Hello, Ms. Miller. I am calling about Celia. ..." Once Angela and the school counselor had finished talking, Angela decided it was time to take Celia to see a counselor in the community, someone who could help Celia deal more effectively with her fears, so she made an appointment for the next morning.

Celia held her mother's hand tightly as she entered the lobby of the counseling office. The building was within walking distance of their home and was situated in a large, Victorian-style house that had been converted into office space. The spacious front porch punctuated with a porch swing and flower pots gave the space a welcoming and homey kind of feeling that Angela liked but that didn't seem to soothe Celia's nervousness. Claudette Mendoza, Celia's new counselor was tall and slender with a bright smile; warm, mocha-colored skin; and long, dark curls that framed her face and fell down her back.

Claudette and Angela had talked briefly on the phone about Celia's anxiety. Claudette, a narrative therapist, hoped that in their first few meetings, she would get to know Celia, understand her story and how she has made sense of her fears. Claudette believed the first step in helping clients, the joining phase, is to learn how clients perceive their worlds and understand their problems. Claudette planned to listen for language that suggested Celia might be crystallizing negative beliefs about herself and for ways she might be internalizing her difficulties.

Claudette entered the lobby and introduced herself. "You must be Angela and Celia. I'm Claudette. It's nice to meet you," she said, extending her hand. "Celia, I thought we could go into my office and get to know each other a little better. Do you think your mom will be okay out here while we visit?" Celia reluctantly followed Claudette down a bright hallway and into the corner office. Celia smiled and walked over to the tall bookshelves that framed a large, open window that looked out over a cozy private garden. The bookshelves were lined with books and several small figurines Claudette had collected in her travels around the world. Claudette noticed that Celia seemed interested in the small bronze statue of the dancing Shiva she had picked up in Delhi. "You can pick that up if you like," Claudette offered. "It is heavy and won't break. That is Shiva, the destroyer of obstacles. Shiva is the bravest of all the Hindu gods."

Celia lifted the statue, carried it to a small armchair opposite Claudette and began examining the small figurine in her hands. "Celia," Claudette began, "Can you tell me a little about why your mom brought you to see me?"

Celia made eye contact and then returned her gaze to the Shiva cradled in her hands. "I get nervous at school," Celia replied. "Sometimes, my stomach hurts so much the nurse calls my mom, and I have to go home. I think my teacher is mad at me. I don't think she believes me about my stomach."

"You're just not sure your teacher sees how much the worry hurts your stomach. How about your mom and your dad? Do they believe you?" Claudette asked.

"Dad says that Luke, he's my brother, is just like Aunt Justine. Luke will try anything. He just wants to have fun all the time. Aunt Justine used to be like that, too, but she got herself hurt really bad playing in Granddaddy's car, and she got most of her sense conked out of her—that's what Luke said. Daddy says I am more like him. He used to get stomachaches a lot, too. Sometimes, Daddy gets so scared he feels like he's getting a heart attack! One time, when we were playing in the car, Luke and me, it rolled in the street. When Daddy saw that, he fell right down in the grass and the ambulance had to come. The ambulance man said Daddy didn't really have a heart attack; it was just all in his head. Luke says I'm just like Daddy; I have problems with my head," Celia explained, a note of sadness punctuating her words. In their second session, Claudette and Celia sat on the floor in front of the coffee table. Claudette placed a piece of paper in front of Celia, along with some crayons and markers. The paper depicted a silhouette of a girl that Claudette had drawn for her. "Celia, think about a time when you felt really worried at school," Claudette prompted.

"You mean like in the lunchroom last week?" Celia asked.

Claudette nodded. "Can you remember how that felt when you first started to feel worried in the lunchroom? What color was that?"

Celia looked over the crayons and, after a moment, held up a yellow-green crayon. "It is like this, kind of a sick-to-my-stomach green."

Claudette nodded and, pointing to the silhouette, asked, "Where does the sick-to-your-stomach-green feeling start? Can you show me?"

Celia chose a spot and began coloring a bit of green in the center of the silhouette. "Right here in the bottom of my stomach."

"Then, what happens?" Claudette prompted.

"Well, it starts to get bigger and bigger. It starts to fill up my whole insides, like this." Celia's delicate silhouette became overwhelmed with green, as she colored furiously on the page.

Claudette leaned forward and scratched her head. "Well, this helps to explain things, doesn't it? Worried stomach can be tricky and can make you believe that the worry has filled up your stomach and your whole body with more worry than will really fit."

"I don't like the worried stomach. Can we make it go away?" Celia asked sincerely.

"Absolutely," Claudette replied, "without a doubt."

Claudette was satisfied with how the last few sessions had gone. She had developed a good feeling for how Celia understands her anxiety, the role her family takes in constructing her vision of herself and feeds her relationship with anxiety, and together they have given it a name—a worried stomach. By giving her worry a name, Claudette believed she had made important steps in externalizing the worry and distancing it from her sense of self. Planning their next steps, Claudette hoped she and Celia wouldn't focus on what is or is not in Celia's head; she would focus on the strengths Celia has that are different from the fearful and somewhat helpless character she and her family seem to believe her to be. Together, Claudette hopes she will draw on these exceptions to her storied understanding of herself and use them to help her to master the tricky nature of the worried stomach. Claudette believes Celia is ready for phase two of narrative therapy: challenging patterns.

Claudette would like Celia to examine her time at school and search for exceptions to the times when she feels overwhelmed by anxiety. As a narrative therapist, Claudette believes Celia is building a story in which she envisions herself almost like a cartoon character, embodying a single personality trait—anxiousness. She would like Celia to see there are many aspects of her personality that she can draw upon. They decided that in their next session she will investigate with Celia the times when she is different, those times when she has been brave.

Celia sat cross-legged in the armchair across from Claudette, her shoes left behind beneath the coffee table, the Shiva figurine from Claudette's bookshelf in her lap. Celia was smiling broadly. "You look like the cat who just swallowed the canary," Claudette commented. "What are you up to?"

"I turned eight on Saturday, and guess what? I walked here by myself! I told Mom that I knew I could do it and that I would be really careful about the cars. I'm not a baby."

"So how was it?" Claudette asked. "I liked it. I felt brave like her." Celia held up the Shiva figurine. Claudette smiled to herself. It was easy to see why Celia might think Shiva was a woman, with its slender waist, the fire behind it that looked something like her mother's braids flying in the wind as she danced above the earth.

"Celia, tell me about other times when you have felt brave like her," Claudette prompted, indicating the figurine. "Tell me about a time at school."

"Hmm, that's hard." Celia paused thoughtfully. "Well, I felt brave on Monday. It was that dumb Simon. He is one of the big kids that is always making fun of me and pushing me around."

Claudette prompted, "What happened?"

"He pinched me right here," Celia replied, pointing to a dark bruise on her cinnamon-colored skin. "He said I should take a bath and then some of the dirt might come off," Celia said angrily. "I yelled at him and told him he better stop or I would tell Miss Blake."

"That was incredibly brave, Celia. You remind me of David in the story of David and Goliath!"

"Yes, I know that story. I guess I kind of was like David!"

"How did you find the courage to stand up to that big kid like that?" Claudette asked, leaning forward.

"I don't know, it just made me so mad for him to say that to me," Celia replied.

"Does that happen a lot at school?" Claudette probed.

"Mmhmm, especially with Simon. He pulls my hair, pinches me, and makes fun of my brown skin. I get a worried stomach just thinking about him," Celia explained, turning the Shiva in her hands. "Last year, my teacher wanted me to sit next to Simon on the bus all the way to the zoo! It was a field trip. I got so worried—" Celia paused "—that I wet my pants. I had to go home, but I was glad."

"I guess your worried stomach kind of protected you from Simon that day," Claudette offered. "Maybe your worried stomach has been trying to tell everyone something that you haven't been ready to tell until now."

"You mean about Simon?" Celia asked.

"Maybe it was trying to tell us that sometimes you don't feel safe at school," Claudette offered.

As Claudette reflected on their session, she was glad that they had been able to help Celia identify times when she had been brave and she felt confident that Celia had begun work on phase three of their time together: re-authoring. Claudette had taken the first steps in reframing or redefining Celia's worried stomach from a problem with her head to a kind of warning system. Claudette hoped that Celia would begin to see herself as both brave and capable as they work together to identify moments of strength and to explore the results of her courage. Claudette also recognized that Celia was experiencing some very real bullying and racism at school. As a social activist, Claudette asked Celia's permission to talk with her mother and to contact the school counselor to see what measures can be taken to stop the bullying and address the racism that seems to be fueling it.

In the following weeks, Claudette and Celia revisited different phases of their work together. Claudette helped Celia recognize the ways in which she had been able to stand up to others on her own behalf and on the behalf of some of the younger children on the playground, despite the worry she sometimes feels in the pit of her stomach. Celia had become proud of her ability to stand up to her brother Luke when she came up with an idea that might get them hurt or in trouble—or both. As Celia began to see herself in a new light, she found herself more willing to take risks, which reduced the arguments between them and Luke and generally changed the way the two of them talked to each other.

One afternoon, Celia announced, "I think today is going to be my last day. I guess I don't have very much trouble with worried stomach anymore. Simon finally quit being such a jerk, and I am

not scared of him anymore anyway." Claudette had noticed the difference in Celia and was already considering approaching the subject of termination as part of the fourth phase: moving on. Celia seemed much more confident, had cultivated an ability to advocate for themself, and had a new vision of herself that Claudette hoped would serve as the foundation for a lifelong story of empowerment and strengthened sense of self.

For You to Consider

1. How have the family stories influenced the way in which Celia initially made sense of her experience of anxiety?
2. Do you think Celia's anxiety can be partly due to her temperament—something inherent in her that gives her a tendency to have an anxiety disorder? Can a belief in a "temperament" and an "anxiety disorder" fit into the view of human nature of a narrative therapist?
3. Do you think focusing on Celia's anxiety being "in her head," as Luke suggests, could have been helpful in any way? Why, or why not?
4. Claudette uses a play-based technique (coloring the silhouette) to help Celia find a name for her difficulty and externalize her problem. How might you have worked to externalize the anxiety if Celia were three, or even five, years older?
5. Claudette makes use of cultural stories to help Celia reframe her own story (David and Goliath and Shiva). What other stories might Claudette have been able to draw upon to help Celia envision herself differently?
6. Do you think offering Celia some concrete ways of dealing with her anxiety (e.g., cognitive disputing, exercising, and medication) could have been helpful?
7. Do you believe that Celia has conquered her anxiety? Why, or why not?
8. In this vignette, Claudette decides to take on an advocacy role with Celia by talking with her mother and school counselor. Do you believe it was appropriate for Claudette to go outside of the relationship to help the change process? When do you think such advocacy roles are important for counselors and therapists?
9. How might you work with Jake, Angela, or Luke using a narrative approach? What benefit do you see in this approach for each?
10. Think about a pattern in your own life, a way of responding to difficulties that you would like to change. Can you think of exceptions or times that you responded differently and with better results? What do you think this means?

Summary

Narrative therapy is a relatively new approach to counseling that was originated by Michael White and David Epston. After personally experiencing the negative effects of the mental health system, White began to develop his own approach to therapy that was much more sensitive to the personal stories of his clients, more optimistic, and future-oriented. Some of the people that influenced him included Michel Foucault, Barbara Myerhoff, Gregory Bateson, and Karl Tomm. In addition, White's wife, Cheryl, was also a particularly important influence on White's work, and she and White eventually established the Dulwich Centre for Narrative Therapy in South Australia. His

approach evolved from a systems to a communication to a postmodern approach. In recent years, John Winslade and Gerald Monk have continued work on this important approach.

Narrative therapy is based on postmodernism, social constructionism, and post-structuralism. Postmodernists question modernism, such as the modernist concepts of empiricism and the scientific method, and many of the assumptions that are based on these ideas. Postmodernism suggests there is no one way to understand the world, no foundational set of rules to make sense of who we are, and no one approach to communication in understanding a person. Social constructionism has to do with how values are transmitted through language by the social milieu (e.g., family, culture, and society) and suggests that the person is constantly changing with the ebb and flow of the influences of significant others, culture, and society. Post-structuralism questions the inherent "truth" of such things as intrinsic psychological structures to which many psychological theorists point in explaining their view of human nature. Narrative therapy is antideterministic, antiobjectivist, and more positive than most past therapies. In addition, narrative therapists believe that realities are socially constructed, realities are constituted through language, realities are organized and maintained through narrative, and there are no essential truths.

In addition to postmodernism, social constructionism, and post-structuralism, some of the key concepts we examined in narrative therapy included understanding client narratives and the fact that we are all multistoried; that some stories are helpful, while others are unhelpful; the dominant and problem-saturated stories with which clients often present; the importance of deconstruction of stories when working with clients; helping clients to move from thin to thick stories; understanding relativism and the nature of multiple realities; how power dynamics in society, as seen by the dominant stories, are internalized; the importance of therapists looking for unique outcomes or exceptions; helping clients re-author their stories; and the importance of not being neutral because neutrality supports the existing oppressive power relationships endemic in society.

There is a range of techniques the narrative therapist can use at varying times, including showing mystery, respectful curiosity, and awe; use of questions; collaboration and reflexivity; reflection, empathy, and verbatim responses; encouraging clients to tell their stories; naming and externalizing the problem and mapping its effects; helping clients identify unique outcomes or exceptions; absent but implicit responses and double listening; considering social and political issues; scaffolding; use of therapeutic documents and other paraphernalia; re-membering; definitional ceremonies (outsider witness groups); reflective teams; and telling and retelling.

Narrative therapy can be viewed in four phases. Phase 1, the joining phase, occurs when the therapist meets the client, begins to build a relationship, and invites the client to share their problem-saturated story; phase 2, examining patterns, is when the client is invited to examine stories that contradict, deny, or oppose the problem-saturated story; phase 3, re-authoring, is when the client begins to build new, more positive stories; and phase 4, moving on, is when the client has developed a new, more positive outlook on life and is ready to leave therapy. Although some techniques tend to be used at certain times, it was suggested that narrative therapy is a free-flowing process in which phases can re-emerge, as the therapeutic process continues.

Relative to cross-cultural issues, narrative therapists realize that most dominant narratives have a particularly deleterious impact on individuals of marginalized groups. Thus, narrative therapists are attuned to how patriarchy and issues of discrimination and inequality impact clients. It was suggested that being neutral is actually siding with the oppressive powers of the larger social system, and thus, it is important to inquire, with all clients, about "isms" in their lives. Ultimately, narrative therapists help clients look at how language in their social milieu and society may have negatively impacted them and might be intimately related to their problem-saturated story. Therefore, narrative therapists tend to be cross-culturally astute and social justice advocates, and cross references to the four *MSJCC* domains with potential questions that can be asked based on the domain were provided. In reference to spiritual issues, one role of the narrative therapist is to

help clients look at how they may have been oppressed by certain religious values but also to help clients feel empowered by developing new religious and/or spiritual stories.

Although more research needs to be conducted on narrative therapy, it has shown some efficacy with increasing self-esteem and decreasing stress response for alcohol dependency, decreasing stress and anxiety, and lowering depression among children and adolescents, increasing children's social and emotional skills, decreasing youth smartphone addiction, alleviating ADHD symptoms among women and among children; decreasing disordered eating among youth; and improving decision-making and career self-efficacy among high school students. Other research on narrative therapy can be found at the website of the Dulwich Centre for Narrative Therapy. Finally, it is suggested that additional quantitative research is needed, and qualitative approaches—such as narratology—can be particularly beneficial for researching the efficacy of narrative therapy.

Key Words and Terms

abductive analysis
absent but implicit listening
antideterministic
antiobjectivist
awe
collaboration
deconstruction
definitional ceremonies
dominant narratives
dominant stories
double listening
empathy
encouraging clients to tell their stories
examining patterns
exceptions
externalizing the problem
future-oriented
inductive analysis
interactive, flexible research design
join
joining
high-level distancing tasks
humanness of research
importance of context
low-level distancing tasks
map the effects of the problem
modernism
moving on
multistoried
narratives
narratology
naturalistic setting
neutrality
outsider witness groups
positive
postmodernism
post-structuralism
power
preferred stories
problem-saturated stories
purposive sampling
re-authoring
reflection
reflective teams
reflexivity
relativism
re-membering
respectful curiosity
re-story
scaffolding
showing mystery
social constructionism
sparkling outcomes
strength-based
structuralism
telling and retelling stories
the person is not the problem, the problem is the problem
therapeutic documents and other paraphernalia
thin descriptions
thick descriptions
unique outcomes
use of questions
verbatim responses

Key Names

Andersen, Tom
Bateson, Gregroy
Epston, David
Foucault, Michel
Monk, Gerald
Myerhoff, Barbara
Tomm, Karl
White, Cheryl
White, Joan
White, Julienne
White, Michael
White, Neil
White, Paul
White, Penni
White, Sue
Winslade, John

CREDITS

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Fig. 11.2a: Copyright © Depositphotos/tonodiaz.

Solution-Focused Brief Therapy

12

Learning Goals

At the conclusion of this chapter, readers will:

- have knowledge about the lives of Insoo Kim Berg and Steven de Shazer and the historical context in which they created solution-focused brief therapy (SFBT)
- understand the social constructionist and postmodern influences on the pragmatic, anti-deterministic, future-oriented, and optimistic view of human nature of SFBT
- understand how Wittgenstein's philosophy concerning language and its relationship to reality affected the development of SFBT and its tendency to normalize problems and believe in the strengths of the client
- be able to identify several key concepts related to SFBT, including postmodernism and social constructionism; having a nonnormative yet normalizing stance; being nonpathologizing; being solution focused and future oriented; focusing on exceptions and client strengths; believing in client readiness; not giving resistance; and the 10 basic assumptions of SFBT
- have knowledge of several common SFBT techniques, including presession changes; being an ambassador by showing curiosity, respect, and acceptance; using listening and empathy; being tentative; use of presuppositional questions, including preferred goals questions, coping questions, exception-seeking questions, and solution-oriented questions; reframing; amplification; complimenting clients; scaling; and homework
- understand the six stages of SFBT: presession change, forming a collaborative relationship, describing the problem, establishing preferred goals, problem-to-solution focus, reaching preferred goals, and ending therapy
- be able to articulate how SFBT honors the subjective worldview of clients and is likely an approach that can be used with a wide range of diverse clients, although some have criticized it for not being more proactive regarding discussing issues related to discrimination and oppression
- examine the efficacy of SFBT, especially in light of its relative newness to the field of counseling and psychotherapy and, to date, the relative lack of controlled studies

> The master therapist, Milton Erickson, was known for practicing unusual interventions that were brief and often at the client's home or workplace. For instance, there is the story of how he once spent less than an hour at the home of a woman who was depressed, lonely, and shy. By visiting her home, he realized she was an expert at cultivating African violets and that she was a committed member of her church. He quickly came up with an intervention: every time there was a birth, wedding, or death at the church, she was to send one of her flowers. She did this religiously, which dramatically changed her life as other church members began to get to know and appreciate her. At her death, the newspaper noted that hundreds of people attended the funeral of the "African Violet Lady." (Gordon & Meyers-Anderson, 1981)

In the beginning, there was Freud. Soon followed disciples, many of whom had profound ideas about the "psyche." As years passed, psychoanalysis lost some of its glitter but still maintained a large base. Slowly, other approaches arose, also mostly concerned with the "inside" of the person, and generally those who practiced these therapies would spend months or years helping clients examine and understand "the problem." Then, one day, an unconventional psychiatrist, *Milton Erickson*, started to practice a new form of therapy. As reflected in the story above, he focused on client strengths, not deficits, and he worked quickly. His work was to greatly affect those at the Mental Research Institute (MRI) in Palo Alto, California. Established in 1959 by *Don Jackson*, MRI included several therapists and researchers who would become household names, such as *Virginia Satir, Gregory Bateson,* and *Jay Haley* (Cade, 2007; Pichot, 2015). Unconventional in their focus, these individuals looked at how communication and rules in systems, particularly family systems, affected individuals within those systems.

In 1966, within MRI, the Brief Family Therapy Center (BFTC) was established. Led by *Paul Watzlawick, John Weakland,* and *Dick Fisch*, BFTC focused solely on helping families solve their problems as opposed to "underlying" issues or global communication and system patterns (Cade, 2007; Pichot, 2015). Although they realized that families were trying their best to fix the "problem," they also saw that the solutions families tried usually resulted in entrenching the problem more. Approaching families with an attitude of experimentation, these therapists were highly active and felt free to use any methods that were ethical and legal to solve problems or lessen presenting symptoms.

Unknown to each other at the time, *Insoo Kim Berg* and *Steve de Shazer* would end up at BFTC for advanced training, eventually meet, fall in love, and marry. What they learned at BFTC would greatly affect the development of SFBT, and although many individuals, like *Bill O'Connell, Bill O'Hanlon, Jeffrey Guterman*, and *Peter De Jong*, impacted the methods and practices of solution-focused brief counseling, Berg and de Shazer are often cited as the early pioneers of this approach.

In this second chapter of Section IV, we highlight the biographies of Berg and de Shazer. We then present the view of human nature from an SFBT perspective; key concepts, techniques, and therapeutic processes of SFBT; social, cultural, and spiritual considerations; and research on the efficacy of SFBT. We conclude the chapter by illustrating this approach with Angela, a member of the Miller family.

Insoo Kim Berg and Steve de Shazer

> Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different? (de Shazer, 1988, p. 5)

Born in Korea on July 25, 1934, Insoo Kim Berg grew up in what most would have called a prosperous and even privileged family in Korea. A few years later, on June 25, 1940, thousands of miles away in Milwaukee, Wisconsin, Steve de Shazer was born to an electrical engineer father and opera-singing mother (Dolan, 2006; Pichot, 2015).

As a young teenager, Berg's world would be shattered when her family's home was bombed during the Korean War. It was at that point that she realized, "It is people, not things, that are important in life" (Dolan, 2007, p. 130). Berg would initially study pharmacy at Ewha Women's University in Seoul (Berg, n.d.a). Then, in 1957, she decided to leave Korea for the United States, where she would earn her bachelor's degree in 1967 and her Master of Science in Social Work (MSSW) in 1969 from the University of Wisconsin–Milwaukee (Dolan, 2007). Meanwhile, de Shazer, growing up in Milwaukee, would earn his bachelor's degree in fine arts in 1964 and, like Berg, his MSSW from the University of Wisconsin–Milwaukee in 1971 (de Shazer, n.d.). But the two had not met—yet.

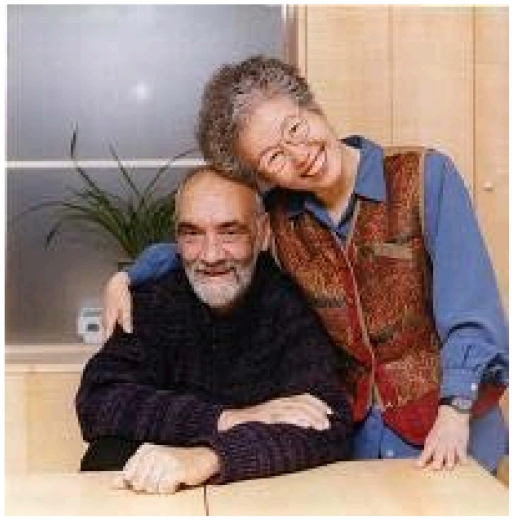

FIGURE 12.1 Insoo Kim Berg and Steve de Shazer

With her MSSW in hand, Berg secured a job at Family Services of Milwaukee, where she worked until 1980 (Berg, n.d.a). Paralleling her work at Family Services, in 1974, she took advanced training programs at the Menninger Institute and at the Family Institute of Chicago. While at the Family Institute, she met with one family for an entire year, as her supervisor and classmates watched her work with this family (Berg, n.d.b). Relying heavily on an insight-oriented approach, Berg increasingly began to question the length of treatment and the intense focus on insight. "These primarily working class families were in a great deal of pain and they were not interested in gaining insight but wished for the pain to go away, and quickly, too, not to wait for weeks, months, even a year" (para. 6). Enthralled by the writings of Haley, Weakland, and others who offered a briefer lens through which to view therapy, Berg moved to the MRI in Palo Alto, where she began to study with those at BFTC.

Like Berg, de Shazer pursued additional training at MRI and, over the years, was mentored by Weakland (Visser, 2013), who introduced them to each other. This union was to be the main impetus for their lasting marriage and for the beginning of SFBT.

De Shazer was a *Ludwig Wittgenstein* enthusiast (George et al., 2015; Visser, 2014). Considered by some to be one of the major philosophers of the 20th century, Wittgenstein's ideas are often seen as a precursor to *postmodernism* (Wittgenstein, 1963). In fact, Wittgenstein was one of the first to challenge the modernist view of the world, such as the primacy of the scientific method. He suggested that language shapes reality, and reality is always changing as a function of the individuals' interactions with others. De Shazer adapted Wittgenstein's philosophy to the therapeutic setting. From this perspective, Wittgenstein's ideas suggest one should not try to have a "deep understanding" of the client's reality or think in terms of internal mechanisms that help to create reality. Instead, if a client says they are depressed, the counselor should first accept that is how the client feels and help the client alleviate their depression through language and discourse.

Influenced by Wittgenstein and intrigued by the work being done at BFTC at the MRI, such as not focusing on the past and focusing on the problem, de Shazer, Berg, and three others decided to start the Brief Family Therapy Center of Milwaukee (Dewell, 2015; Pichot, 2015). Mentored by Weakland and others, the center slowly grew. As the team began to treat large numbers of clients, they noticed that *solution-focused* interventions, not problem-focused ones, seemed to have better and quicker results. In fact, the group realized that the average number of sessions clients spent in therapy was six, yet most counselors, with their insight-oriented approaches, expected clients to be in therapy for months, if not years. They also realized that most counselors saw clients as diseased and were continually hypothesizing about their clients as if the therapist knew something about them that they did not know about themselves (de Shazer et al., 2021; Trepper et al., 2006).

Deciding that clients were their own best resources and that they could be helped in a short amount of time, they decided to use video recordings and live observation to examine what techniques had the quickest and best results. In fact, this is how de Shazer (1988) came up with his famous *miracle question* that is quoted at the beginning of this biographical sketch.

Knowing they could quickly and effectively work with clients, the team contracted with one health insurance company for a flat fee of $500 per client, regardless of how long treatment took (Wheeler, 2006). As they continued to work, they increasingly believed that clients could be seen from a more positive frame of reference and be helped in a short amount of time. In fact, de Shazer came to be called the "man with *Occam's razor*," which is the belief that the simplest solution is often the best solution (Berg, n.d.b). Eventually conducting informal follow-up studies of their clients, de Shazer showed that this new short-term approach to counseling was effective (Visser, 2013).

As their successes grew with this new solution-focused approach, the group decided to publish the *Underground Railroad*, a newsletter highlighting their novel ways of working with clients. Their success with the newsletter and with clients, and the popularity of Berg and de Shazer's publications, would make the couple nationally and internationally known. Berg wrote numerous articles, served on editorial boards, developed multimedia resources demonstrating solution-focused counseling, and wrote 10 books, some of which include *Family Based Services: A Solution-focused Approach* (Berg, 1994), *Solutions Step-by-Step* (Berg & Reuss, 1998), *Tales of Solutions* (Berg & Dolan, 2001), *Interviewing for Solutions* (De Jong & Berg, 2013), *Children's Solution Work* (Berg & Steiner, 2003), and *Brief Coaching for Lasting Solutions* (Berg & Szabo, 2005). Similarly, de Shazer lectured worldwide, served on editorial boards, and wrote several popular books, some of which include *Patterns of Brief Therapy* (1982), *Keys to Solutions in Brief Therapy* (1985), *Clues: Investigating Solutions in Brief Therapy* (1988), *Putting Difference to Work* (1991), *Words Were Originally Magic* (1994), and *More than Miracles: The State of the Art of Solution-Focused Therapy* (de Shazer et al., 2021).

Although consumed by his work, de Shazer was also a person whose heart was in the arts. A classically trained musician, at one point in his life he earned a living from playing jazz on his saxophone. He was also a gourmet cook, artist, baseball fan, and philosophy enthusiast. Sadly, while on one of his lecture trips, he contracted pneumonia and died in Vienna on September 11, 2005 (Iveson, 2005). Although Berg was also constantly busy with her work, she managed to find time to involve herself in activities as varied as yoga, classical music, gardening, physical activities, and reading. Known as a caring, funny, warm, optimistic, and enthusiastic professional, Berg passed away peacefully on January 10, 2007 (Insoo Kim Berg, 2007) (see Box 12.1).

BOX 12.1 Want to Meet Insoo Kim Berg and Steve de Shazer?

Want to hear a brief biography about Berg and de Shazer and find other tidbits of information about them? Go to https://silver.odu.edu/psyadm/ to see caricatures of the two of them talking about themselves and their theory. Click on the postmodern door, and go into their office.

View of Human Nature

Solution-focused brief therapy (SFBT) is a *pragmatic*, *anti-deterministic*, and *future-oriented* approach that offers hope about the ability of the client to change quickly (Dewell, 2015; Lutz, 2014). This *positive approach* rejects the notion that individuals have an inherent tendency toward mental health problems or illnesses and focuses almost exclusively on solutions and on client strengths, not on client deficits or problems.

De Shazer et al. (2021) suggested that SFBT is not a theory-based approach, and one can understand this argument when remembering that most of the techniques were pragmatically chosen based on their utility—whatever worked quickly would be used. And many SFBT counselors know little about the theory that drives it. However, it is clear that *social constructionism* and

postmodernist philosophies informed the team that first developed SFBT (Gergen, 2015; Guterman, 2013; Visser, 2013).

With these theories underlying SFBT, the counselor assumes that reality is a function of social interaction, which is especially influenced by the language used within an individual's social sphere as well as the language that is endemic in cultures and society. In fact, they would argue that the nature of reality is limited by language, as ideas and concepts, which have their basis in language, are affected by the context in which they evolve. Thus, reality is particularly malleable and must always be questioned. This approach differs from most other theories, which assume there is something inherent within a person that functions to create one's reality. Such inherent structures put forth by other theorists range from a tendency for the individual to have a self-actualizing tendency within, as the existential-humanists suggest; to those who suggest there is genetically based cognitive map that lends direction to the way one sees the world, as some cognitive therapists assert; to others who insist there is an id, ego, and superego that jointly form the individual's personality structure, which psychoanalysts put forth.

The postmodern, social constructionist position asserts that pathology, for all practical purposes, does not exist, since one cannot prove that it is inherently found within the person (Gergen, 2015; Guterman, 2013; Wittgenstein, 1963). Thus, this perspective assumes that problems can be viewed as challenges that are inherent in a language-based system. Seen from this viewpoint, how the counselor brings themself into the relationship is critical to helping the client overcome their problems. If the counselor believes that pathology exists within the client, they will find this pathology. If the counselor believes the problems are system-based (e.g., residing within the family or community), they will find this to be the case. However, if the counselor assumes that problems are a function of the language used by the client within their social sphere (including the counselor's office!), opportunities for change with the counselor through discourse, and then eventual action, are plentiful.

Given the philosophical assumptions inherent in social constructionism and postmodernism as well as the pragmatic and future-oriented focus of SFBT, most SFBT counselors believe clients can change quickly; the client is the expert; the client has strengths that can be expanded upon; it is important to focus on solutions, not problems; when developing treatment plans, it is important to focus on the future; and the client, in dialogue with the counselor, can create a problem-free language, as they move toward new and positive ways of living in the world (Dewell, 2014; O'Hanlon & Weiner-Davis, 2003).

Key Concepts

Some of the key concepts that underlie narrative therapy include postmodernism and social constructionism; having a nonnormative yet normalizing stance; being nonpathologizing; being solution focused and future oriented; focusing on exceptions and client strengths; believing in client readiness, not resistance; and the 10 basic assumptions of SFBT.

Postmodernism and Social Constructionism

Like narrative therapy discussed in Chapter 11, SFBT has a strong postmodern and social constructionist perspective, and the reader is referred to Chapter 11 to read the sections on *postmodernism*, *post-structuralism* (a subcategory of postmodernism), and *social constructionism* within the Key Concepts section. Here, we offer a quick overview of those philosophies and how they relate to SFBT.

Postmodernism has sometimes been defined as the questioning of *modernism*, which states that truth can ultimately be uncovered and that underlying structures are responsible for shaping how one comes to understand the world (Weinberg, 2008). They suggest that much of what has

been handed to us as "truth" by the modernists is only the modernists' particular "take" on reality. Therefore, therapists who act in a so-called "objective" manner and assume there are certain inherent mechanisms that lead a person down a path toward a particular personality style have become entrenched in believing that particular truth.

Social constructionism views knowledge and truth as something that is constructed through conversations (Gergen, 2015; Rudes & Guterman, 2007). Fitting comfortably alongside postmodernism, this philosophy suggests that language used and the discourses we have with others are key factors in the development of reality. In other words, nothing is fixed (see Box 12.2).

BOX 12.2 Difference in Boys' and Girls' Math Scores: Science or Myth?

When I (Neukrug) grew up, except for those careers that were traditionally gender specific (e.g., nursing), there were few women who went into math and science careers. In fact, over the years, it was assumed that one of the many reasons women did not go into these careers was because they simply did not have the innate math or science ability; this was believed to be reality. However, recent studies suggest that this achievement gap has shrunken and may not even exist to any large degree (APA, 2014; Balart & Oosterveen, 2019; Ganley & Lubienski, 2016). So what used to be seen as a genetic reality now appears to be a belief system that many of us (including many girls and women) bought into! What other realities do we currently buy into that may turn out to be false?

Because language creates reality through discourse, the major responsibility of a counselor would be to recognize that the language they use will likely impact the client (as the client's language will likely impact the counselor). Therefore, the counselor must carefully choose their words, knowing the influence of language on the person. In fact, *not* saying certain things will reinforce existing ways of being for the client. Also, since reality is constantly changing and a function of language, it is assumed that one can never fully know the inner world of another; "all one can know is the verbal expressions of another's experiences" (Rudes & Guterman, 2007, p. 388). For postmodernists and social constructionists, even the idea of an "inner world" is seen as a cultural by-product, not something that necessarily exists. From this perspective, it would make sense to question any counselor who states that they know the client's inner world because they supposedly know the functioning of some hypothesized inner structures (e.g., id, ego, and superego; incongruent vs. congruent self). Hypothetically, what one says is the color blue may be someone else's red, and what one says is depression may be experienced differently by another, and what one says is happiness also may be experienced differently by another (see Box 12.3).

Finally, Freedman and Combs (1996) suggest four premises that summarize much of what has been said: *realities are socially constructed*, *realities are constituted through language*, *realities are organized and maintained through narrative*, and *there are no essential truths* (see Chapter 11 for a longer discussion of these premises).

BOX 12.3 Color Therapy

Imagine there was a therapy that stated color preference was an indication of mental health, and the closer a person's favorite color was to "red," the healthier they were. Those who liked red most were very healthy, those who liked orange were pretty healthy, those who liked yellow were somewhat healthy, and so forth down the spectrum to green, then blue, and then to those

who liked violet, who were really unhealthy. Now, imagine that this therapy became so popular that it was accepted throughout the land, and most people "knew" that color preference was related to mental health.

Now, imagine a client sees a counselor who is a "color therapist." Naturally, one of their first questions is to ask the client what their favorite color is. They say "blue." Well, immediately, the counselor would assume the client is not mentally healthy. After all, blue is way down the list toward violet. So the counselor would treat them and try to change their favorite color. They even have a systematic way of having them work up the hierarchy toward red. If they practice the system every day, they will eventually get closer to red, says the counselor. After a few months, they have worked their way up to green, and the counselor says they think the client might want to consider taking some medication, for medication will help them experience the red more often. The counselor tells them that after a few years of experiencing more red, they can try to reduce their medication, as they may begin to like red on they own.

Frustrated that they are not making progress rapidly enough, the client decides to see a new counselor. The new counselor is clearly unconventional and does not even believe in color therapy. They ask the client to tell them what their problem is. The client states, "Well, everyone says that liking blue is bad, and so I must be mentally ill. What do you think?" This counselor replies by saying, "How about we don't focus on the color right now. Instead, let me ask you: What do you want your life to look like? Where do you want to take therapy? What do you want as your end goal? What would make you happier?"

With the first counselor, there is an external reality based on preconceived notions about colors. This reality has been bought into by many. In fact, a whole system of working with clients has been developed. Almost everyone "knows" and believes in this approach. The second counselor, however, does not have these preconceived ideas, and, indeed, even questions the moral authority that asserts that this reality exists. This counselor does not believe there are any internal structures that mediate mental health based on color. They question its basis and want the client to focus on future goals. This is the basis of SFBT!

A caveat: As alluded to earlier, we would be fools not to mention that there are many SFBT counselors who know little to nothing about postmodernism and social constructionism. For them, underlying theory is irrelevant; process is everything. The bottom line, for these counselors, is that counseling is positive, quick, future oriented, and solution focused. This, they are confident, works, and the philosophies of social constructionism and postmodernism matter little.

Nonnormative Yet Normalizing

Because reality is in the eye of the beholder, there is no "normal" way of being that is the "correct" way to act. Therefore, SFBT counselors are *non-normative* in that they do not compare their clients' behaviors to the behaviors of others to try and have their clients act like "most people." However, SFBT counselors note that it is sometimes important to *normalize* clients' experiences by letting them know that others have had similar experiences to theirs (Corcoran, 2012; Thomas & Nelson, 2007). Thus, a client who is experiencing panic attacks might want to know that the symptoms they have seem like the symptoms thousands of other people have. These types of comparisons can alleviate the anxiety some clients have when they believe they are the only ones who have them.

Nonpathologizing

Bavelas and others (2013) note that one key assumption of SFBT is to embrace a nonjudgmental stance regarding the problems clients bring with them to counseling. Thus, counselors should

avoid viewing client problems as pathological, even when the client presents with behaviors that traditionally have been classified in such a manner. In fact, SFBT asserts that embracing a point of view that assumes client pathology and views clients as inherently deficient is the result of a kind of mental health professional "group think":

> [W]hen a counselor describes clients in terms of pathological categories, this indicates that he or she has conversed within the context of a professional community, which in turn, has chosen to organize its knowledge accordingly. (Guterman, 2013, p. 26)

Counselors who take a *nonpathologizing* stance, will, of course, still be faced with difficult and perplexing clients. However, they approach their clients in positive ways and with the belief that a strength-based approach can be helpful. Do schizophrenia, bipolar disorder, personality disorders, and other disorders exist? Well, we suspect something that looks like those disorders, as described in *DSM-5-TR*, are exhibited by some clients. However, counselors can approach each of these clients nonjudgmentally and with the knowledge that they can help them find positive solutions in their lives while not assuming there is little to no hope for them because they are "disordered."

Solution Focused and Future Oriented

Today, most counselors are trained to focus on problems, likely because the earliest psychotherapists were physicians trained as analysts, who examined the underlying causes of disease. Partly due to its success in medicine, this problem-focused model became embedded in the mental health professionals' work. Thus, many counselors today see clients as diseased or deficient due to problems from the client's past. They believe such clients must be diagnosed appropriately and treated for their past problems. These counselors tend to use disease-laden, problem-focused language. SFBT counselors, on the other hand, are *future-oriented*, focus on client *strengths* and help clients identify their *preferred future* (Bavelas et al., 2013; O'Connell, 2003). They stay away from pathologizing language. Table 12.1 contrasts the use of questions from a problem focus with those from a solution focus.

TABLE 12.1. Problem-Focused Versus Solution-Focused Questions

Problem-Focused Questions	Solution-Focused Questions
• How can I help you?	• How can this be helpful to you?
• Could you tell me about the problem?	• What would you like to change?
• Is the problem a symptom of an underlying issue?	• What are you already doing that is he helpful?
• Can you tell me more about the problem?	• What is helping?
• How are we to understand the problem?	• Can you describe your preferred future or past?
• What defense mechanisms are operating?	• What resources are available?
• How many sessions will we need?	• When will we know when to end?

Note. From B. O'Connell, "Contrasting a Problem Focus with a Solution Focus," *Solution-Focused Therapy*, 3rd ed., p. 20. Copyright © 2012 by SAGE Publications.

Although some have suggested that the use of a diagnostic manual, like the *DSM-5-TR*, reinforces the disease model, others believe that it is not the *DSM* that is problematic but rather the way a counselor approaches the manual (Strong & Busch, 2013). A counselor who has a disease focus sees the manual as identifying diseases and client deficits; on the other hand, an SFBT counselor who has a positive, strength-based focus can see benefit from such a manual as well as other assessment processes (Guterman, 2013):

> Accordingly, my solution-focused counseling approach involves conducting a formal intake, including a biopsychosocial history, a mental status examination, a diagnostic impression, and making psychiatric referrals for clients who meet the criteria for certain diagnoses (e.g., major depressive disorder, bipolar disorder, and schizophrenia). I also use a solution-focused approach during the assessment process by identifying the client's resources and strengths as well as their problems. In solution-focused counseling, the intake is interventive rather than merely a passive information gathering process. (p. 26)

In short, the SFBT counselor sees value in obtaining information and then, with the client, uses a *solution-focused* approach to address problems and concerns.

Exceptions and Client Strengths

Like narrative therapy, one focus of SFBT is to help clients recognize that their lives have not been filled only with problems; there have been times when they have been strong, felt good about themselves, and have dealt effectively with issues that have arisen (Dewell, 2015). Therefore, one role of the SFBT counselor is to inquire about those times and to help clients see how they have effectively coped, so such mechanisms can potentially be amplified and used in the future. Thus, the SFBT counselor is vigilant about looking for times when the problem has not saturated the client's life—looking for *exceptions* to what is sometimes described by narrative therapists as the "dominant, problem-saturated" way of living.

Readiness, Not Resistance

> What other models view as "resistance" is generally seen as (a) people's natural protective mechanisms or realistic desire to be cautious and go slowly, or (b) a therapist error, i.e., an intervention that does not fit the clients' situation. (Bavelas et al., 2013, p. 11)

When working on my doctorate, I (Neukrug) went to a workshop on how to counsel resistant adolescents. As the workshop leader started to present, the first thing he said was, "There are no resistant adolescents, only bad therapists." I was taken aback. After all, aren't adolescents known to be resistant? Well, given the state of many adolescents, I would still argue that adolescent clients are probably more difficult to work with than many other clients. However, there is no doubt that the workshop leader had a point. This presenter was suggesting that every adolescent, even the most "resistant," could be helped by some therapist. SFBT makes a similar point. Rather than labeling a client "resistant," it suggests that clients who have not been able to change have simply not yet found an available mechanism to change (Guterman, 2013). In fact, given a different counselor, a client who has difficulty changing could indeed be able to change.

Instead of viewing clients as resistant, De Jong and Berg (2013) and de Shazer (1988) describe three types of clients and relate their ability to change as more of an issue of *readiness not resistance*. They suggest that *customers* are ready to work on defining their preferred goals and on problem-solving, *complainants* are often able to identify their problems and come to a consensus with the counselor about what needs to be addressed but have trouble coming up with solutions, and *visitors* are shopping around—testing the waters to see if they want to try out counseling. Visitors may not be able to identify or want to talk about problems and cannot come up with goals for treatment.

O'Connell (2012) suggests that attitudes toward change are important if a client is to make progress. A client who is ready for change (e.g., a customer), "knows what to change," "knows how to recognize signs of change," "wants to change," is "aware of obstacles to change," and is "confident of making changes" (p. 25). However, it should be recognized that complainants can become

customers, and visitors can become complainants, under the right circumstances. And what is the right circumstance? It's probably finding the right counselor who can connect with the client and subsequently help that client move toward identifying issues and focusing on solutions.

Basic Assumptions of SFBT

With its postmodern and social constructionist philosophical basis and its pragmatic, strength-based, future-oriented, and brief focus, several *basic assumptions* about how to work with clients have been identified by de Shazer, Berg, O'Hanlon, and others (Dewell, 2015). Box 12.4 highlights these assumptions, and descriptions of each follow.

BOX 12.4 Basic Assumptions

1. Change is constant and inevitable.
2. If it ain't broke, don't fix it.
3. If it works, do more of it.
4. If it's not working, do something different.
5. Clients come to us with resources and strengths.
6. Small steps can lead to big changes.
7. There is not necessarily a logical relationship between the solution and the problem.
8. The language for solution development is different from that needed to describe a problem.
9. No problems happen all the time; there are always exceptions that can be utilized.
10. The future is both created and negotiable.

1. **Change is constant and inevitable.** Our lives are filled with changes—from the developmental changes we undergo as we move through life to the unexpected changes that occur from some unforeseen event to the changes we choose to make because we believe it will better our lives. Recognizing the importance of change to feel better, SFBT counselors see change as opportunity, and they invite clients to try out new behaviors and new ways of being.
2. **If it ain't broke, don't fix it.** Some approaches counselors use look for problems, even when they don't exist, and assume there are additional issues "underneath," even when the client isn't presenting symptoms. The SFBT approach makes no assumptions about underlying issues and does not look to change behaviors the client has not identified as problematic.
3. **If it works, do more of it.** As obvious as this might sound, clients sometimes have not focused on what does work in their lives, and conversations about what is working and the possibility of doing more of what works can be an important focus in counseling.
4. **If it's not working, do something different.** In contrast to many traditional approaches that presume client resistance when clients do not try new behaviors, SFBT counselors assume clients have not found what behaviors do work and will encourage clients to try other behaviors until some are found that do work for the client.

5. **Clients come to us with resources and strengths.** In contrast to approaches that view counselors as experts in identifying client pathology, this approach views clients as the experts who come in with resources and strengths that the counselor can help them identify, as the clients identify new paths toward making positive changes in their lives.
6. **Small steps can lead to big changes.** If you've seen the comedic movie *What About Bob*, you'll understand how small steps can lead to big changes—well, at least in theory. In the movie, Richard Dreyfuss plays a psychiatrist who wrote a book called *Baby Steps* and is treating Bo Wiley (Bill Murray), who has multiple phobias. Like in the movie, SFBT embraces a commonsense assumption that if clients accomplish small steps over time, they can move "gradually and gracefully forward ... to subsequently be able to describe things as 'better enough' for therapy to end" (de Shazer et al., 2021, p. 2).
7. **There is not necessarily a logical relationship between the solution and the problem.** Whereas traditional therapies spend extraordinary amounts of time dealing with issues that seemingly "caused" the problem, SFBT focuses on fixing the problem by focusing on solutions—and solutions are not so obviously related to the problem. For instance, the spouse who is depressed and feels unloved decides to take a cooking class. Suddenly, their life is filled, and the "relationship issues" are gone.
8. **The language for solution development is different from that needed to describe a problem.** Because solutions, not problems, are being focused upon, this approach uses a tone that is optimistic, future oriented, positive, and hopeful. In contrast, problem-oriented approaches tend to focus on deficits and pathology and are filled with negative language and depressive symbols and words.
9. **No problems happen all the time; there are always exceptions that can be utilized.** Although clients often feel they are engulfed by their problems, in actuality, all people have times when there are exceptions to their problems. One role of the counselor is to help explore these exceptions, help determine what is different in the client's life during those exceptions, and elicit new solutions from this newly found information.
10. **The future is both created and negotiable.** As opposed to the more traditional view of therapy, which sees individuals as "locked into" a way of being based on their inherent ways of living in the world, this approach believes that people are the "architects" of their destiny and, in conversation with the counselor, can cocreate a new future.

Therapeutic Techniques

There are a vast number of techniques a SFBT counselor could use, as long as the focus of the session was congruent with the general philosophy of the solution-focused approach. Some of the more frequently used techniques include noting presession changes; being an ambassador by showing curiosity, respect, and acceptance; using listening and empathy; being tentative; using presuppositional questions, including preferred goals questions, coping questions, exception-seeking questions, and solution-oriented questions; reframing; amplification; complimenting clients; scaling; and homework.

Noting Presession Changes

SFBT counselors assume that clients who are seeking counseling are ready for change. Therefore, counselors will often ask clients to keep track of changes that occur between the time they made

the appointment and actually coming in for their first or subsequent sessions (Bavelas et al., 2013; de Shazer et al., 2021). Thus, when the client does arrive, the therapist prompts for *presession changes*, by asking something like, "What changes have you noticed since the time you made your appointment?" (or "... since your last appointment").

Being an Ambassador (Showing Curiosity, Respect, and Acceptance)

In contrast to therapeutic models, where counselors approach the client as if they are the "expert," the SFBT counselor enters the relationship as an *ambassador* to a foreign country might (Murphy, 2015). For instance, an ambassador would be respectful, curious, and show acceptance of people in another culture in their attempt to understand the ways of the people. In a similar fashion, the SFBT counselor enters the relationship humbly and is curious about the client's predicament, respectful of the client's ways of being, and accepting of what the client tells them. Ultimately, such an approach helps to elicit information from the client and strengthens the therapeutic alliance.

Listening and Empathy

Listening and *empathy* are important skills for the SFBT counselor, particularly at the beginning of the relationship (O'Connell, 2012). This is because when clients initially enter counseling, their talk is often problem saturated, and they generally want to discuss their problems in detail. Giving clients the opportunity to talk about their problems is respectful and an important aspect to building the relationship and understanding their problems (De Jong & Berg, 2013). However, such a problem focus should not be extensive and should change in a relatively short amount of time to *solution talk*.

Being Tentative

> SFBT therapists do not marry their ideas or techniques; instead, they hold loosely to assumptions, apply techniques lightly, and are cautious with their language. (Thomas & Nelson, 2007, p. 8)

Similar to what De Jong and Berg (2013) call holding a *not-knowing posture*, *being tentative* means that the counselor approaches the client with an attitude that the client is the expert and that any hypotheses or interpretations about why the client might be struggling should be cautiously held (George et al., 2015). The counselor demonstrates tentativeness by being humble, respectful, and curious; by not acting as the "expert"; and by the types of responses they give. For instance, SFBT counselors can often be heard starting sentences with such phrases as the following:

- Could it be that ... ?
- Am I correct in assuming that ... ?
- Correct me if I'm wrong but ... .
- I would guess that ... .

Use of Presuppositional Questions

One of the most important solution-focused skills, the use of *presuppositional questions*, has far-reaching effects on the tone and direction of the relationship. Called presuppositional because they are asked in a manner that presumes change will occur (De Jong & Berg, 2013; de Shazer et al., 2021; O'Hanlon & Weiner-Davis, 2003), questions can be classified in one of five areas:

(a) what the client is hoping their future will look like (*preferred goals questions*), (b) what the client is doing and whether it is working for them (*evaluative questions*), (c) how the client has coped in the past with their problem (*coping questions*), (d) when exceptions to the problems have occurred (*exception-seeking questions*), and (e) how the client's life would be if the problem did not exist (*solution-oriented questions*; Bannink, 2010; De Jong & Berg, 2013; de Shazer et al., 2021; Franklin et al., 2012; Trepper et al., 2014). Box 12.5 offers a scenario concerning Phil, who has sought counseling due to depression and anxiety. This scenario will be used to exemplify how different kinds of questions might be used.

BOX 12.5 The Case of Phil

Phil, a 29-year-old single male, is severely anxious and has suffered with anxiety and depression most of his adult life. He is the oldest of three children and describes growing up in a family that was highlighted by a lot of screaming, chaos, and few boundaries. He notes that his parents had an "on and off" loving relationship that seemed to match the chaos that was prevalent in the family. Being the oldest, he states that he had many rules placed on him, that he was judged much more harshly than his younger siblings, and that he was often given the responsibility of taking care of his younger brother and sister. He was often told that he "better do well in school," or his future would be "hell." He grew up wanting to have more stability in his life, a steady job, a "quiet family," and a sense that his life had purpose. However, despite obtaining his bachelor's degree in psychology, he has had trouble obtaining a job and states he has had no luck in the dating scene. He is afraid he will always be searching for a job, a partner, and stability. In an effort to feel better, some of the things that Phil has tried include reading self-help books, taking antidepressant medications, exercising, and being in in-depth, long-term counseling.

Preferred Goals Questions

Having its roots in the narrative therapy concept of preferred stories (Freedman & Combs, 1996), *preferred goals questions* help clients identify where they want to end up and give the therapist a sense of how the client's life will look and how long the client believes it will take for positive outcomes to be reached. When devising these types of questions, the problem is not focused on, but the client's hoped-for future is. Here are some questions that could be used when working with Phil (or any other client):

- Phil, what will be the first sign that things are getting better?
- How long do you think it will take before things get better, Phil?
- How will you know when things are getting better, Phil?
- If this were to be the best helping session you ever had, can you imagine what goals you would identify to focus upon and how you might try to reach them?
- How would you act differently in the future, Phil, if coming here has been worthwhile for you?
- If your life was better in one month, six months, or a year, what would be happening? What might you be doing differently, Phil?

Evaluative Questions

Evaluative questions focus on the kinds of client behaviors that have had a positive effect on the client's life and in what manner they have helped the client achieve their goals. For instance,

in Phil's case, the following questions might be asked (consider how similar questions could be adapted to most clients):

- When were the use of antidepressants helpful, Phil?
- What aspects of "depth" therapy were helpful to you, Phil?
- Phil, you've mentioned that you have been exercising a lot lately. How has that worked for you in helping you feel better?
- What about reading self-help books, Phil? How have they helped you with your depression and anxiety?
- Out of all the ways you've tried, what was the most effective in alleviating your anxiety and depression, Phil?

Notice that, when asking evaluative questions, it is important to focus on those aspects of Phil's life that could be helpful in his attempt to find solutions and spend only limited time on what has not worked, as such discussions are wasteful and rehash past failures. For instance, if Phil says, "Depth therapy just made me feel worse," then a discussion of depth therapy would be limited, except for those aspects that were helpful.

Coping Questions

Coping questions assume there have been times when the problem did not saturate the client's life and asks clients to describe those times when they have successfully dealt with their problems. Remembering to presume that there have been times when the client was successful (being presuppositional), the counselor might ask, "What ways have you found to cope with [the problem]?" but not ask, "Have there been times when you were able to cope with [the problem]?" In Phil's case, a counselor might ask the following presuppositional, coping questions (consider how these kinds of questions could be adapted for most clients):

- So, tell me Phil, in what ways have you been successful in coping with your depression in the past? What about the anxiety?
- Phil, what other ways have you tried that were successful in alleviating your depression and anxiety?
- I know you had trouble getting out of bed this morning because you were so depressed, Phil. Tell me, what did you do to get yourself up and going?
- Phil, your depression seems to have impacted your eating, and you've lost some weight. Tell me Phil, when you *have eaten*, what enabled you to be able to eat?
- Phil, when you think back on your life, what things helped to alleviate your depression and anxiety?

Exception-Seeking Questions

Exception-seeking questions explore what was going on in the client's life when they were not experiencing the problem. Here, again, there is the presupposition that the client *has* had exceptions in their life. In Phil's case (or with any client), the following questions could be used:

- I know there have been times in your life, Phil, when you have not felt depressed. Can you describe them for me?
- What was going on in your life when you did not feel depressed, Phil?

- When undergoing hardships, people often have moments when they feel good. Can you describe times like that for me? Phil, what is going on with you during those times?
- You mentioned that you were less depressed and less anxious a couple of years ago, Phil. What was going on in your life then that seemed to ward off your depression and anxiety?

Solution-Oriented Questions

Solution-oriented questions have clients zero in on how their lives would be different if the problem did not exist. One kind of solution-oriented question, the *miracle question*, has gained much notoriety. Mentioned in the biographical sketch early in the chapter, in Phil's case, the "miracle question" would be: "Phil, suppose a miracle happened while you were sleeping and the problem that brought you here was solved. What would your life look like? How would things be different?" In addition to the miracle question, other types of solution-oriented questions can be asked of clients. For instance, Phil (or any client) can be asked the following:

- Phil, how would your life look different if you were not depressed or anxious?
- Phil, if you were given a magic pill that would somehow make everything better, how would your life look?
- If you suddenly had the power to change anything in your life, so you would feel better, Phil, how would things be different?
- Phil, if there was some deity that could suddenly make your life better, what would your life look like?

Amplification

To focus on strengths and stay away from problem talk, counselors will encourage *amplification* of client successes by having expanded discussions with clients about solutions that have worked (Lee, 2013). For instance, referring back to Phil in Box 12.5, if Phil had remarked that exercise had been effective in alleviating his depression, the counselor might respond by saying any of the following:

- Exercise really seemed to help you through your depression; tell me more about how that worked for you.
- I'm impressed with your ability to deal with your depression with exercise; can you give me more details on how you were able to do that?
- That's a really interesting way of changing your life; how exactly do you think that materialized for you?

Complimenting

Complimenting, or reinforcing client strengths and resources, is a basic skill that SFBT counselors will use to encourage clients in their continued efforts at solution-building (de Shazer et all., 2021; Dewell, 2015). For instance, relative to Phil's past "exercise" regime, his therapist might say, "Sounds like you did a great job at scheduling exercise into your life so that it would alleviate some of your depression." Or if Phil has worked on increasing his communication skills with the person he was dating, and if this led to a decrease in depression, the therapist might say, "I am really impressed with your newfound ability to effectively communicate with Jaime. It really seems to have enriched your relationship and made you feel better." Compliments can be a natural part of therapy and, unfortunately, have too often been avoided.

Reframing

Clients frequently come to therapy with an attitude that there is something wrong with them—that they're deficient in some manner (Lee, 2013). In fact, it is not unusual for clients to view themselves as having a mental disorder. Such thinking can lead to a sense of helplessness and lack of control over their situation. With such thinking sometimes being related to dominant language perpetuated in society, such as when clients view themselves as disordered because they have a diagnosis found in the *DSM-5-TR*, one role of the SFBT language is to counter this understanding with a positive *reframing* of the client's situation. For instance, Ivey and Ivey (1998) offer a reframe of how personality disorders, found in *DSM*, can be viewed as a "logical response to developmental history" (p. 334). In doing this, they point out the positive aspects of what they call *personality styles* (instead of *personality disorders*; see Box 12.6).

BOX 12.6 Positive Reframe of Personality Disorders

Personality Style	Paranoid	Schizoid	Schizotypal	Antisocial	Borderline	Histrionic
Positive Frame	It is important to watch out for injustice.	It is useful to be a loner or independent of others at times.	It is useful to have the ability to see things differently than others see them.	It is sometimes necessary to be impulsive and take care of our own needs.	Intensity in relationships is desirable at all times.	All could benefit at times with open access to emotions.

Personality Style	Narcissistic	Avoidant	Dependent	Obsessive–Compulsive	Passive–Aggressive
Positive Frame	A strong belief in ourselves is necessary for good mental health.	It is useful to deny or avoid some things.	We all need to depend on others.	Maintaining order and a system is necessary for job success.	All of us are entitled to procrastinate at times.

Note. Box 12.6: Allen E. Ivey and Mary Bradford Ivey, "Positive Reframe of Personality Disorders," *Reframing DSM-IV: Positive strategies from developmental counseling and therapy*, pp. 338. Copyright © 1998 by John Wiley & Sons, Inc.

Scaling

Strictly speaking a type of evaluative question, because this technique has become widely used by a wide variety of therapeutic approaches, we have listed it separately. *Scaling* involves asking clients to subjectively rate themselves between a 0 and a 10 on an imaginary scale that assesses any of several experiences, feelings, or behaviors from the past, present, or future (see Figure 12.2).

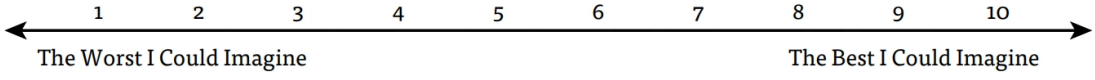

FIGURE 12.2 Scaling

Scaling helps clients to quickly assess where they have been and whether they have made progress (De Jong & Berg, 2013; de Shazer et al., 2021). For instance, referring back to Phil in Box 12.5, we could ask him the following scaling questions:

- With 0 being equal to the worst your depression ever was and 10 being equal to the best you could possibly feel, can you tell me, Phil, where on a scale of 0 to 10 you are today?
- Phil, on the scale of 0 to 10, how effective do you think the thought stopping has been for you?
- Phil, being that today you rated yourself a 2, where do you think you could end up on your imaginary scale of 0 to 10?
- I know, Phil, that when you first started counseling you rated yourself at a 2 on our imaginary scale. Where do you think you are today?

Homework

Homework, from an SFBT perspective, means that clients have identified areas where they want to change, and the counselor is "supportive and persistent" in inquiring about the direction clients want to go, not prescriptive about how clients will get there, but encouraging clients to do behaviors that clients have identified will help them get there (de Shazer et al., 2021; George et al., 2015; Kim, 2014). Thus, homework is generally based on something the client is already doing, thinking, or feeling that seems to be pointing them in a positive direction, although the therapist might gently suggest the client do it or do more of it. In a sense, the ball is in the clients' court, as they decide how to engage themselves in moving toward their preferred goals.

The Counseling Process

SFBT is fast, often lasting about six sessions, with gaps between sessions being a common practice, unlike most other therapies (George et al., 2015). Thus, five or six sessions may last over 10 weeks. Typically, during each session, a short amount of time is initially spent with small talk, a somewhat lengthy discussion of preferred goals and how to get there follows, and sessions finish with compliments about the success of the session, any goals the client wants to work toward (homework), and a short discussion concerning whether the client wants to return (Kim, 2014). Preferred goals, and ways to reach them, are generally identified during the first session, and follow-up sessions focus on adapting what has worked for the client in moving toward their goals or identifying new goals.

SFBT counseling can be viewed through a series of stages, which include presession change, forming a collaborative relationship, describing the problem, establishing preferred goals, problem-to-solution focus, reaching preferred goals, and ending therapy (De Jong & Berg, 2013; O'Connell, 2012). Stages are passed through quickly, and it is not unusual for clients to cover stages 0 through 4 within the first session, although early stages can be repeated in later sessions. Table 12.2 summarizes the techniques most likely found during the different stages, and this is followed by a short description of the stages.

TABLE 12.2. Stages and Most Likely Used Techniques

Stages	Techniques
Stage 0: Presession change	• Requesting that clients note presession changes
Stage 1: Forming a collaborative relationship	• Being an ambassador (e.g., by showing curiosity, respect, and acceptance) • Listening and empathy • Being tentative
Stage 2: Describing the problem	• Being an ambassador (e.g., by showing curiosity, respect, and acceptance) • Listening and empathy • Being tentative
Stage 3: Establishing preferred goals	• Preferred goals questions • Complimenting
Stage 4: Problem-to-solution focus	• Evaluative questions • Coping questions • Exception-seeking questions • Reframing • Amplification • Complimenting • Homework
Stage 5: Reaching preferred goals	• Scaling • Listening and empathy • Complimenting • Homework
Stage 6: Ending therapy	• Scaling • Listening and empathy • Complimenting • Homework

Stage 0: Presession Change

With the knowledge that clients are generally ready to change when they seek counseling, prior to the first session, the counselor and client decide on an appointment time, and the counselor asks the client to become cognizant of any changes that are made prior to their first meeting. When the counselor and client do meet, one of the first questions the counselor asks is, "Did you notice any positive changes from the time you made your appointment till now?" If yes, the counselor can help the client identify what it was that they did differently and how they could continue to do so in the future.

Stage 1: Forming a Collaborative Relationship

SFBT counselors downplay power differentials between themselves and their clients and build the kind of trusting and collaborative relationship that will allow clients to identify their strengths and resources and be the foundation for eventually helping them find their own preferred goals. Techniques that help initially build this kind of relationship include being an ambassador (showing curiosity, respect, and acceptance), being a good listener, using empathy, and being tentative.

Stage 2: Describing the Problem

Obviously, most clients do not seek out counseling, unless they are struggling with some problem. Although the focus of therapy is almost exclusively on solutions, it is important that when clients first enter counseling they feel heard, so many of the same skills that are used to form the collaborative relationship are initially used to listen to clients' problems. However, De Jong and Berg (2013) suggest that problems only need to be listened to for about 15 minutes before solutions are focused upon. Although others might argue that a longer time is needed for clients to feel like their problems are heard, what is most critical is that clients feel comfortable during the beginning phase of therapy, especially during the first session. Rather quickly, the counselor will begin to use other techniques that will move clients toward focusing on preferred goals.

Stage 3: Establishing Preferred Goals

One of the first steps toward helping clients focus on preferred goals is to have them begin to respond to questions about what they would like to see in the future. Letting go of the problem-saturated way of viewing the world is critical for clients if they are to make progress quickly. Thus, it is important that questions that focus on preferred goals, such as those noted earlier, are asked of clients early in therapy.

Stage 4: Problem-to-Solution Focus

To help clients focus on solutions instead of problems, all the presuppositional questions highlighted earlier are used (i.e., preferred goals questions, evaluative questions, coping questions, exception-seeking questions, and solution-oriented questions). Such questions clearly highlight solutions to their problems. During this stage, counselors also support clients in their new solution-building focus in a number of ways, including amplification, which encourages clients to give more detail concerning how they have used their strengths and resources, so they can increasingly employ these strategies as they work toward their preferred goals; reframing, which provides a different take on past behaviors in an effort to normalize and depathologize how clients view themselves; homework, where the counselor supports and encourages clients to focus on their preferred goals; and complimenting, in an effort to reinforce clients' efforts toward reaching their preferred goals.

Stage 5: Reaching Preferred Goals

Often, by the end of the first session, clients have developed a new outlook and have shifted from focusing on problems to focusing on solutions. By this stage, they have begun the work toward reaching their preferred goals. Counselors can help clients evaluate the effectiveness of their new solution focus by using scaling and can tweak goals in future sessions, with the focus being on clients working quickly to implement their changes. Counselors are reinforcing of clients by being good listeners and showing empathy, discussing homework, and complimenting them on their efforts.

Stage 6: Ending Therapy

> [B]rief therapy means, among other things, "as few sessions as possible and not one more than necessary." (de Shazer, 1991, as cited in Hoyt, 1996, p. 61)

Because SFBT is brief, as soon as clients show facility in reaching their preferred goals, counseling is finished. Follow-ups can be conducted to ensure that clients are continuing their solution-focused orientation. As in stage 5, the chief techniques include listening and empathy, complimenting, homework, and scaling.

Social, Cultural, and Spiritual Issues

> Expertise as therapists should be in eliciting the clients' expertise. (Selekman, 1997, p. 7)

SFBT assume that clients are themselves a unique resource, equipped with tools that will not only assist them in creating positive changes within their lives but also with supporting counselors to become more effective helpers. Such tools are in part created and sustained from cultural and social assets that culturally competent counselors rely upon to help identify solutions with clients.

Because SFBT stresses the importance of curiosity, respect, and acceptance; relies upon collaboration not authoritarianism; uses empathy; and honors the subjective worldview of the client, one can see how it lends itself toward working with a wide range of clients (Kim, 2014). Several authors (e.g., Cheung & Jahn, 2017; Holyoake & Golding, 2012; Kayrouz & Hansen, 2020; Miller & de Shazer, 2000; Suitt et al., 2016) have shared some of the features of SFBT that support it as a culturally responsive approach.

- **client empowerment:** Counselors take a "not-knowing posture" when working with all clients and approaches the client tentatively and with the sense that the client is the expert about their life. This acknowledges and validates client experience and uses the clients' multiple social, cultural, and spiritual identities as unmined resources and strengths useful to enact change. In addition, through techniques such as complimenting, counselors can empower clients to leverage these resources.
- **shift from stigma of past to promise of future:** As SFBT does not focus heavily on exploration of the past or "the problem" but on positive, future-oriented solutions, counselors can minimize stigma with help-seeking, while they focus on client strengths for present and future behavioral changes.
- **the power of language:** Language, used to describe oneself or to conceptualize a presenting concern or potential solution, is not neutral, as it is embedded within social structures and cultural systems. For clients who have experienced marginalization placed upon them by social structures, the SFBT counselor can openly address the power of language and assist clients in reducing its power when it has resulted in negative stereotypes.
- **pragmatism:** As a down to earth approach, SFBT focuses on problem-solving and goal setting by using small steps toward success, which can be culturally aligned for the client, producing larger changes. In addition, success tends to be measured by the client's own subjective experience (e.g., scaling) as opposed to some "externally imposed 'yardstick' that may not be culturally relevant" (Fiske, 2007, p. 321).
- **focus on interpersonal context:** Within cultures where commitment and care to family and community is a cultural value, involving others, whether in session or through goal setting, can support culturally aligned behavior change.

Valdez et al. (2018) identified eight elements that counselors should consider, as they adapt SFBT interventions to match client culture (Valdez et al., 2018):

- **language:** Should SFBT techniques be delivered in the client's native language?
- **persons:** Is ethnic and gender matching between the counselor and client possible, and would it lead to better outcomes?
- **metaphors:** Infuse culturally relevant symbols and colloquialisms of the client's cultural group into the counseling process.
- **content:** Include client's beliefs, values, traditions, and customs in solution building.
- **concepts:** Take into account how the client defines, expresses, and views the treatment of presenting symptoms within the client's culture to contextualize and conceptualize the presenting problem and possible solutions.

- **goals:** Be attentive to the client's values, traditions, and customs in the development of treatment goals and defining successful outcomes.
- **methods:** Use culturally adaptive interventions and techniques that are congruent with the client's culture and gender and do not impose bias.
- **context:** Consider the whole client, including the systems in which they live, as part of SFBT process (e.g., level of acculturation, immigration status, and degree of social support).

Relative to religious and spiritual issues, the SFBT therapist should be effective with a wide range of religious and spiritual people—even those who hold very rigid religious convictions (Kelly & Maynard, 2014). This is because SFBT does not have a stake in what any religious group believes; instead, it cares about what each client wants for their preferred goals, including preferred goals relative to their religious and spiritual life. As spirituality may be a salient cultural variable that influences how clients see themselves and their presenting concerns, SFBT counselors can help identify the positive aspects of their client's spiritual or religious identity, incorporating those qualities in solution-building. For example, counselors can adapt exception questions to solicit information from clients, regarding times when their spiritual or religious practices and beliefs supported their psychological functioning and, thus, can be useful for goal setting (Ime, 2019).

For whom would this approach not work? SFBT would probably not be particularly beneficial for clients who want to spend a considerable amount of time "getting to the root" of their problems. For instance, clients who believe that ongoing "in-depth" work with a therapist is critical to knowing oneself would not make good candidates for this brief approach. Also, clients who are not seeking to change (e.g., "the visitor") would not be particularly helped by this approach, although sometimes "visitors" can become "complainants" or even "customers."

Efficacy of Solution-Focused Brief Therapy

SFBT has been demonstrated as an effective approach to treat an array of psychological and behavioral problems across populations and uses fewer sessions than other approaches. Since its beginning, there has been sustained attention to evaluating the effectiveness of SFBT at the end of treatment as well as up to 18-months-posttreatment follow-ups. With the increased number of training resources and manuals available to counselors, there has been a significant growth in the number of randomized control trials (RCTs) since 2000 (Institute for Solution-Focused Therapy, 2022; Kim et al., 2019).

RCTs, meta-analytic studies, and systematic reviews report that SFBT yields significant positive outcomes, with often up to 75–80% of clients experiencing positive results (e.g., Abusaidi et al., 2018; Corcoran & Pillai, 2009; Franklin & Hai, 2021; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2013; Hsu et al., 2021; Jalali et al., 2017; Kim, 2008; Kim & Franklin, 2009; Orsolini et al., 2021; Schmit et al., 2016). Collectively, these studies indicate support for the use of SFBT across several areas of counseling:

- **child and adolescent academic and behavior problems:** Improved self-esteem, self-efficacy, externalizing behaviors, social competence, school attendance, grade point average, assignment completion, and accuracy. Decreased behavioral problems and psychological concerns, such as anxiety, depression, obsessive–compulsive disorder, and conduct disorder. Improved externalizing behaviors and social competence and decreased behavioral problems.
- **adult mental health:** Improved general mental health outcomes, internalizing and externalizing symptoms, life satisfaction, and school/work adjustment. Decreased depression, anxiety, and substance misuse and related psychological problems, such as depression and trauma symptoms.

- **marriage and family considerations:** Improved family and couples adjustment, marital intimacy and satisfaction, parenting skills, and communication skills. Decreased depression and family distress.
- **occupational rehabilitation:** Improved return to work rates and reduction of number of sick days, gains in psychological functioning, and decreased depression and anxiety symptoms.
- **health and aging:** Improved quality of life and positive adjustment to illness. Reduced aggression and wandering behaviors among elderly patients and lower depression.
- **crime and delinquency:** Increased adaptive problem-solving skills. Reduced aggression, antisocial tendencies, and lower recidivism rates with less severe recidivist offenses for individuals released from incarceration.

Although in many studies SFBT was just as effective as other therapeutic approaches, its therapeutic benefits were reached in therapy much quicker (Gingerich & Peterson, 2013). In addition, available research shows small to large effect sizes in terms of positive changes for anxiety, depression, and substance misuse for children, adolescents, and adults from different ethnic groups (Kayrouz & Hansen, 2020), including those in European, South American, and Asian countries (see Cheung & Jahn, 2017; Suitt et al., 2016).

Despite the ever-increasing body of research that shows that SFBT is effective across a range of psychological and behavioral concerns, there are a limited number of controlled, experimental studies, and thus, there continues to be a range of opportunities for researchers and practitioners to collaborate and improve the body of available SFBT efficacy research (Kim et al., 2019). Some of the limitations, which can be turned into potential of areas of research, include the following (Gingerich & Eisengart, 2000; Gingerich & Peterson, 2013; Kim et al., 2019; Suitt et al., 2016):

- use of a randomized group design or acceptable single-case design;
- focus on a specific, well-defined disorder;
- comparison of treatment and control (waitlist) group(s);
- evaluation of the use of treatment manuals or procedures for treatment adherence;
- limited exploration of within-session, between-session, and posttreatment process and outcomes;
- use of outcome measures with demonstrated reliability and validity;
- limited inclusion of racial/ethnic groups and groups of other identities (e.g., sexual orientation and ability status);
- limited sample sizes to detect within and between-group differences reliably; and
- publication bias (i.e., publishing only studies that demonstrate SFBT effectiveness and/or studies with statistically significant findings).

In sum, there is still more work to be done to showcase the effectiveness of SFBT across various concerns with different groups. However, available research over the past four decades is promising.

The Millers

The following shows Angela going through SFBT. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Angela's Experience With a Solution-Focused Brief Therapist

Angela reached for her robe and slowly rolled out of bed. "Can't sleep?" Jake asked, only half awake. Angela found her slippers in the darkness of the early morning and slipped down the hall. She checked on Luke and then on Celia, and then she rechecked the front and back doors. This pattern had become a weeks-long routine in which Angela woke, often close to 1 a.m., and often was not able to get back to sleep. Sitting at the kitchen table in the dark, Angela closed her eyes and took stock, noting that her exhaustion was starting to have consequences in her life. She was losing focus at work, she wasn't taking time to paint or be creative, and perhaps more telling, she found herself losing her temper with Jake and the kids often enough that her crankiness had become the rule and not the exception.

By the time the workday had begun Angela was already exhausted and on the verge of tears. She picked up the phone, knowing that she would have to get help if she was ever to get good sleep again. The phone rang several times before she heard a voice at the other end of the line, "Hello, this is Lou Thomas."

"Um, hello," Angela said, suddenly self-conscious. "My name is Angela, and I was calling to see if you could help me with a problem I've been having for about a month and a half." She paused a moment and then said, "It started when I had gone to a dinner party with some friends of mine. It was a big party for a guy who was running for city council. Anyway, there were a lot of people there, and I was mingling. Sometime during the party, someone stole my purse. Whoever it was got my wallet, my I.D., my phone with my calendar, the keys to my car and to the house. ..." Angela felt a wave of panic fill her body as tears streamed down her face.

"Angela, I am really sorry to hear about this. I can't imagine how frightening that must have been for you. I can hear the vulnerability you are feeling," Lou responded.

"Well, that's why I'm calling. I know it's crazy, but I just don't feel safe. That creep is out there somewhere, and he knows where I live. He knows where I am supposed to be better than I do—after all, he has my calendar! I haven't been able to sleep, even though my husband has changed all the locks. I feel sick to my stomach just thinking about it," Angela explained. "I really think I need to see someone and get a grip on myself."

"I see. This is a distressing situation, but perhaps, together we can puzzle out a solution," Lou began. "If you like, I can meet with you on Thursday at 11:00, and we can talk. This may seem strange Angela, but sometimes just making a call to get some support can be the start of some small but important improvements in a problem that, in the beginning, seems overwhelming. I wonder if you would keep track of anything that you notice between now and Thursday that seems even a little bit better."

"Well, yes, I'll try," Angela agreed. "Thursday at 11:00; I'll see you then."

Angela climbed the narrow steps to Lou's office, feeling anticipation mixed with a bit of anxiety. She sensed herself resisting the urge to look behind her, aware of this feeling of being followed. She acknowledged a familiar feeling that she was not entirely safe. Angela took a deep breath and opened the door to Lou's office. Lou, tall, somewhat thin with warm brown eyes welcomed her and motioned for her to sit.

Angela began to explain how difficult it had become for her to sleep or concentrate, since her purse was stolen. She admitted, "I was pretty nervous leaving the house to come to this meeting. I am at my wits' end! Part of me feels that I am blowing this way out of proportion. People get their purses stolen all the time, don't they? Jake and I have done everything we can to secure the house, so why am I still so afraid?"

Lou, as a solution-focused therapist, has as his central aim to help Angela shift her focus from her problem and onto her resiliency and strength and to give some careful consideration to how she will use these characteristics to find a solution to her fears. Lou replied, "Angela, I am frankly

amazed that you have been able to continue to get to work and even to come to my office when you have been so frightened. How do you think you have been able to do that?"

"To be honest, I don't know. I guess I've just been pushing myself to get through the day for Jake and the kids. I just wish I could crawl in bed and never come out. I know that sounds extreme. It doesn't make sense even to me, but that is really how I feel."

"There is a part of you that is keenly aware of how afraid you have been, and yet, at the same time, you've been able to reach inside and find a well of courage that you've drawn from to get out of bed and carry on. Where are you getting all this courage?"

"Well, it sounds a lot better when you say it. I feel like a coward." Angela smiled at Lou. "I don't know how I do that. I think I just realized that I don't want to live like a prisoner."

"Help me to gain a little better picture of what it will look like when you are not living like a prisoner," Lou began probing.

"I wouldn't be afraid all the time. I wouldn't be so worried that there was someone out there ready to hurt me or my family." Angela replied.

"That makes a lot of sense. You'll know our time together has been successful when you are feeling confident again about your safety. Angela, can you tell me about a time since your purse was stolen when you have not felt really terrified or very distracted?"

"Well, things actually improved a lot after Jake changed the locks on the house, and then, they got a little better again when we contacted a person who specializes in identity theft, and she worked with us to monitor our credit. But I think it is the unknown part that is still so frightening to me. You know, the idea that this guy is out there somewhere, and he could find me and hurt me or my family."

"If you were to think about the feelings that you have been experiencing, say on a scale from 0 to 10, where 0 is the most frightened that you can imagine being and 10 is a feeling of safety and comfort both at home and in the community, where would you say that you are right now?" Lou asked.

"Hmmm, well, that's a good question." Angela considered Lou's question. "There was a time once when I was more afraid than I am now, when I was a child, and I was separated from my parents in an airport in Germany. I was afraid for weeks after that. ... I would say I'm at about a 4 now."

"I see. So you can remember being more frightened than you are now, and this feels more like a 4. If we were to make just one small step toward your goal, to, say, a 5 or 6, what would have to change?" Lou asked, now very curious about how Angela would begin to construct a solution.

"I think a 5 would be if I felt safe at home. In my head I know I am safe there, but feeling safe in my heart would be a step in the right direction." Angela considered a moment. "But to get there I think I need to trust myself—and Jake, too—that we have done everything we can to make sure the house is secure. That's all anybody can do."

"A 5 would mean feeling safe at home and having a very clear sense that you and Jake had done all you could together to respond to this theft. That makes sense to me." Lou looked at his watch, surprised how quickly the time has passed. "Angela, as we are coming to a close, I have one last question: What changes have you noticed, since you called to make your appointment?"

"Well, it's funny you ask. I did notice that last night I didn't wake up until 3:00; usually, I wake up at about 1:00. That was a welcome change, it has been exhausting waking up so early. This time, I just reached out and touched Jake instead of getting out of bed to check on the kids. It took a while, but I did get back to sleep. That counts as two things, I guess, I slept a little longer, and I was able to get back to sleep."

"That sounds like a pretty important difference to me—you had said the sleeplessness was really getting to you. It sounds like you are already on your way to finding a solution to this problem," Lou pointed out.

Lou conceptualizes his counseling in seven stages: stage 0, pre-session change; stage 1, forming a collaborative relationship; stage 2, describing the problem; stage 3, establishing a preferred

outcome; stage 4, problem-to-solution focus; stage 5, reaching a preferred outcome; and stage 6, ending therapy. Lou believes therapy should be brief and that as soon as Angela is able to put effective strategies into action, they should be ready to end therapy.

Lou was happy with his first session with Angela. In stage 0, after Angela's initial call, she was able to notice small but meaningful changes that helped her to enter their first session with a sense of hope in finding a solution to her feelings of fear and vulnerability. He had formed a solid collaborative relationship with Angela, and her resiliencies and strengths have been highlighted (stage 1). Lou now understood the problem as Angela perceived it (stage 2) and made use of a scaling technique to frame where she is now with her concern and where she hopes to be when she is ready to end therapy (stage 3). As he prepared for their second meeting, Lou hoped to help Angela begin to let go of her problem-saturated talk and to focus on solutions. As Lou finished his session notes he noted that though Angela was on her way, her thoughts still seemed to drift to "problem thinking."

"This was a rough week," Angela began, "It seemed like some things were a little better, but still, I felt upset and even a little depressed all week. Ultimately, I just decided to skip the farmers' market with the kids Saturday, and I could tell they were disappointed. Getting sweet kettle corn at Mr. Shank's stand is one of our favorite things to do on the weekend, but I just didn't want to be around all those people," Angela sighed.

"Angela, I was thinking as you were talking—I wonder how things would be for you if this problem was no longer there?" Lou mused.

"That's a really interesting question," Angela replied, looking Lou in the eye for the first time in that session.

"How about you imagine this? You can close your eyes to help you imagine, if you wish. The evening winds down, pretty much the same way it does every other evening; you climb into bed and eventually drop off to sleep. But as you are sleeping, a miracle happens. Somehow, your problem is just lifted from you, and it is completely gone. As you wake up in the morning, you have a sense that something has changed. All the familiar feelings of dread and fear are simply gone. Angela, what is the first thing you notice is different as you are waking up?"

"The first thing I would notice is that I would have slept past the sunrise. Maybe Jake would already be up making coffee, and I would have the whole bed to myself," Angela replied, a bit of whimsy in her voice.

Lou prompted, "What would you notice next?"

"I would get out of bed and feel relaxed. I wouldn't be racing to the kids' rooms to check on them; instead, I would go take a long shower and then join Jake for coffee," Angela replied.

"You would be taking more time for yourself, perhaps lingering in the shower," Lou offered.

"Yeah, I think so. The next thing I would do differently is that I would go out on the patio next to the garden and read the paper. I haven't felt comfortable being out there in the open like that, but if this problem were gone, I could enjoy the patio and the garden again; it is one of my favorite places," Angela explained. "I'm realizing that this fear isn't so much about scary, difficult things like panic attacks—Jake struggles with those now and again—for me, it is more the loss of all the little things that added up to be the pleasures of my life. I feel like those have been taken from me."

"So, put like that, is there one small step that you could take tomorrow morning to begin to take back some of the pleasure in your life?" Lou asked.

"Well, I guess I could do some of those things I enjoy even when I feel anxious or blue; at least I would have that back," Angela mused.

As Lou began to write his session notes, he reflected on Angela's gradual shift from problem-saturated talk to a focus on solutions. He felt encouraged that she was able to come up with small steps that have the potential to really turn things around for her, which would be essential if she is going to make the transition from stage 4, problem-to-solution focus, into stage 5, reaching a preferred outcome.

At the opening of their third session, Lou noticed that Angela seemed to have something she wanted to tell him. "I've been so distracted lately, I had forgotten my birthday was coming. After I left your office, I went home and found the kids had packages for me on the hearth, and Jake had made me a cake—it looked like a train wreck, but it was delicious. We had such a nice afternoon I just kind of forgot about my purse and that whole mess." Angela seemed to be enjoying telling Lou about her surprise party; Lou hadn't ever seen her so animated. "The big surprise was that Jake had gotten tickets for a concert at the stadium. I didn't think we would be able to go—I thought it would just be too expensive. Anyway, I don't want to tell you how much I wanted to get out of that. When we heard about the concert four or five months ago, I was really excited about it, but when Jake showed me the tickets, I thought I was going to be sick—the thought of all those people … . But when I looked at Jake, I knew I couldn't ruin his surprise."

"You were in between a rock and a hard place. What did you decide to do?" Lou asked.

"While I was getting ready, I kept thinking about how I didn't want to go, and then, I remembered that idea I had last week—that maybe I could just enjoy some things for me. I wasn't sure exactly how I was supposed to do that—enjoy something I was afraid of—but it dawned on me that I didn't want that guy who got my purse to take my birthday present from us, too. I got it in my head that I was going to have fun, and that was that!"

"And how was it?" Lou prompted.

"It was a lot of fun. I was so exhausted I slept through the night and past dawn, just as if there really was a miracle."

"I imagine it does feel like a miracle, but it seems to me that your own efforts made the evening what it was. You paid attention to how you were feeling and the thoughts going through your head. Somehow, you settled on the idea that you were going to take back your birthday and enjoy this time with your husband and put the theft behind you. I really applaud you," Lou replied, eyes sparkling.

"Well, I guess you are right about that. You know, I have felt almost like my old self again. It really is such a relief." Angela beamed.

Angela and Lou were reaching the end of her therapy, stage 6. Angela had begun to implement the solutions she has developed with Lou, and she was finding her difficulties have been easier to overcome than she had expected. Her therapy had been very brief, only three sessions, helped along by the fact that her fears were spurred by a specific event and not a longstanding pattern of anxiety. Not only did Angela find a solution to a problem that was beginning to become entrenched, she also learned a strategy for looking for solutions on her own. Additionally, she gained confidence in her ability to solve problems, even those that seem irrational or overwhelming.

For You to Consider

1. In what ways do you think Angela and Jake experience anxiety differently? How are their experiences similar? Do you think Jake would have responded as well to solution-focused therapy as Angela seems to have?
2. Angela's therapy was very brief. How comfortable are you with the brevity of her therapy? Why?
3. In this case, do you believe that brief therapy will have long-lasting effects?
4. Do you think there are instances when brief therapy will not have long-lasting effects? Explain.
5. Lou used a scaling technique and asked Angela to scale her feelings of fear. Can you think of anything else Lou could have chosen to scale that might have been as effective for Angela?

6. Can you come up with other ways in which Angela could have made herself feel safer?
7. Do you think a solution-focused therapist should offer other ways for a person to feel safe? For instance, what if Lou suggested that Angela buy some pepper spray or learned to use a handgun and carried one around with her? Is it the place of the solution-focused therapist to make such suggestions?
8. Do you think it would be legitimate if a therapist, who was not solution-focused, spent months examining deep-rooted reasons (e.g., a person not feeling safe due to lack of attachment to parents early in life) as to why Angela may be "holding on to" her anxiety about the theft of her purse?
9. Sometimes clients are uncomfortable with the miracle question and are reluctant to use their imaginations in session. What other tools did Lou have at his disposal had Angela not responded to the miracle question?
10. Can you think of a problem in your life that you would like to be rid of? How would you use scaling to build a solution of your own? How about the miracle question?

Summary

The precursor to the development of SFBT can be traced back to Milton Erickson as well those who worked at the MRI in Palo Alto, CA. However, it is Insoo Kim Berg and Steve de Shazer who are seen as the originators of this approach to therapy. Having both spent some time at MRI, the couple eventually developed the Brief Therapy Center of Milwaukee, which initially modeled itself after the Brief Therapy Center at MRI. Noticing that clients could be helped in much shorter times than had been previously thought, the couple and their colleagues experimented with new forms of treatment and eventually developed SFBT, which focused on solutions, not problems. From their newsletter, the *Underground Railroad*, as well as the numerous books that the couple wrote, SFBT quickly gained national and international recognition.

The view of human nature of SFBT is pragmatic, antideterministic, future oriented, and optimistic about the possibilities of client change. Of particular interest to de Shazer was the philosopher Wittgenstein, who believed that language was critical to the development of a person's reality and that there was no objective reality. This view tended to normalize each person's problems in the sense that problems were not viewed as inherent but, instead, seen as a function of the conversations people had with others and of endemic beliefs in culture and society. This philosophy was incorporated into the manner in which SFBT is practiced. Although most solution-focused techniques are based on a social constructionist and postmodern view of the world, many SFBT therapists are more familiar with the process of conducting SFBT and less with the philosophies that underlie its approach.

A number of key concepts were stressed in this chapter, including the postmodernist and social constructionist basis of the approach; the fact the approach is nonnormative yet normalizing in that it does not compare a person's problems to what is considered "normal" in society but, on the other hand, helps to normalize a client's experience by noting that others have had similar experiences; the tendency not to pathologize; a solution focus and future orientation; the importance of looking at client strengths and to exceptions to clients' problems; looking at clients in terms of readiness, not resistance; and an examination of 10 basic assumptions to SFBT.

In this chapter, a number of techniques were expounded upon, including requesting that clients note presession changes; being an ambassador (showing curiosity, respect, and acceptance); using listening and empathy; being tentative; asking preferred goals questions, coping questions, exception-seeking questions, and solution-oriented questions; reframing client responses; amplification

of client solutions; complimenting clients; using scaling to assess progress; and collaborating with clients about homework they think would be useful.

As the chapter moved on, we demonstrated how the techniques in SFBT might fit into six stages that included presession change, forming a collaborative relationship, describing the problem, establishing preferred goals, problem-to-solution focus, reaching preferred goals, and ending therapy. Stages are passed through quickly, and it is not unusual for clients to cover stages 0 through 4 within the first session, although early stages can be repeated in later sessions. Therapy also tends to be brief, and gaps between sessions might be longer than what is usual for other approaches.

Relative to social, cultural, and spiritual issues, it seems that SFBT could be helpful to a broad range of clients, particularly because it stresses showing curiosity, respect, and acceptance and honors the client's subjective worldview. The "not knowing posture" may also be conducive to diverse clients in that it suggests approaching clients tentatively and respecting cultural differences. We suggested several ways in which SFBT philosophy is congruent with culturally responsive practice, and we introduced eight elements that are useful for culturally adapting SFBT interventions. Relative to religious and spiritual issues, SFBT is only concerned about an individual's preferred goals and can support whatever religious or spiritual values may be associated with those goals. Finally, SFBT is probably less helpful with those who are seeking self-reflective, long-term psychotherapy that looks at "intrapsychic" issues.

A fair amount of research has been conducted on SFBT in its relatively short lifespan, indicating that therapeutic benefits, including reduction of mental disorder symptoms and related psychological problems, can usually be reached more quickly when SFBT is applied. Recent studies showed success with a broad range of groups that focus on a wide range of mental disorders and psychological problems. Although some expertly designed controlled studies have been conducted, such studies are not the norm and more research of the kind is needed.

Key Words and Terms

acceptance
ambassador
amplification
antideterministic
basic assumptions
being tentative
complainants
complimenting
coping questions
customers
empathy
evaluative questions
exceptions
exception-seeking questions
future-oriented
homework
listening
miracle question
modernism
nonnormative
nonpathologizing
normalizing
not-knowing posture
Occam's razor
positive approach
postmodernism
postmodernist
post-structuralism
pragmatic
preferred future
preferred goals questions
preferred outcome questions
presession changes
presuppositional questions
readiness not resistance
realities are constituted through language
realities are organized and maintained through narrative
realities are socially constructed
reframing
respect
scaling
showing curiosity
social constructionism
solution focused
solution talk
solution-oriented questions
stage 0: presession change
stage 1: forming a collaborative relationship
stage 2: describing the problem
stage 3: establishing preferred outcomes
stage 4: problem-to-solution focus
stage 5: reaching preferred outcomes
stage 6: ending therapy
strength-based approach
strengths
there are no essential truths
visitors

Key Names

Bateson, Gregory
Berg, Insoo Kim
De Jong, Peter
de Shazer, Steve
Erickson, Milton
Fisch, Dick
Guterman, Jeffrey
Haley, Jay
Jackson, Don
O'Connell, Bill
O'Hanlon, Bill
Satir, Virginia
Watzlawick, Paul
Weakland, John
Wittgenstein, Ludwig

CREDITS

Fig. 12.1: Brief Family Therapy Center, "Insoo Kim Berg and Steve de Shazer," Copyright © by Brief Family Therapy Center. Reprinted with permission.

13 Relational-Cultural Therapy[1]

Learning Goals

At the conclusion of this chapter, readers will:

- gain a biographical understanding of Jean Baker Miller and the historical context in which she created relational-cultural therapy (RCT)
- understand the postmodern, social constructionist, humanistic, collectivist, relational, developmental, and feminist underpinnings of RCT
- have a cursory knowledge of the feminist movement and influential scholars who developed feminist therapy
- be able to identify the eight principles that form some of the key concepts related to RCT
- articulate important techniques of RCT, including respecting the client, showing curiosity and wonder, being nonpathologizing, and demystifying the counseling relationship; demonstrating acceptance, authenticity, and empathy; analyzing counselor–client power differentials; encouraging discussion about oppression and marginalization; encouraging empowerment, high self-esteem, assertiveness, and emotional identification and expression; and asking questions about the client's life
- be able to describe the eight guidelines that underlie the therapeutic process in RCT
- consider the importance of using the RCT framework with various clients of marginalized statuses and how this approach aligns with critical race theory and intersectional theory
- review the kinds of populations with which RCT has been shown to be efficacious and note some instruments that have been developed to examine the ability of a person to develop a healthy connection with others, a key component of RCT

I (Neukug) remember sitting in a circle of 50 men at a large men's "encounter" group. There was a talking stick that was being passed around. If you had something to say, you would take the stick and stand up and say it in the middle of the circle. One of the men picked up the stick, moved to the middle of the circle, and started to speak. It was right after the first Gulf War. He said, "Saddam Hussein, he is my brother." So, I'm thinking, "What is he talking about; how could this cruel dictator be our brother?" He goes on to say, "Saddam, like so many of us men, are filled with aggression,

1. The authors are grateful to Madeline Clark and Susan M. Long for their contributions to a previous version of this chapter in the second edition of *Counseling Theory and Practice* (Neukrug, 2018).

which we must learn to control. Unfortunately, he did not learn well, but all of us have it." I start to think—"You know, this guy might have something." I think of my own life, my own feelings of aggression, and how I've dealt with them. Yes, Saddam is my brother, unfortunately—maybe fortunately. And like Saddam, we do have to learn how to deal with that dark side of our maleness. So when I decided to add this very important chapter on relational–cultural and feminist therapy, I knew that it was not my place to write the chapter, so I invited a woman to take the lead. So after having read all the other theories in this text, all but one other written by White men, let's take a look at a theory created by women and summarized mostly by women.

Relational–cultural therapy (RCT), pioneered by *Jean Baker Miller*, was the first theory to focus on the impact that gender, relationships, and culture have on individual development and presenting concerns in counseling and mental health. Although RCT is unique, it is generally grouped with a wide variety of *postmodern* theories that focus on individuals' relationships with *power*, *privilege*, and *oppression* and how they intersect.

In this final chapter of section IV, we highlight the biography of Miller, credited as the founder of RCT. We then describe feminist theory as a contributing framework to RCT; the view of human nature from a RCT perspective; key concepts, techniques, and therapeutic processes of RCT; social, cultural, and spiritual considerations; and research on the efficacy of RCT. We conclude the chapter by illustrating this approach with Ann, a member of the Miller family.

Jean Baker Miller

> I wanted to find work that would help people, that would be interesting, and that also would enable me to make a living. At the time of graduating college in 1948, my friends could find only clerical jobs. There were not many fields open to women, at least that I was aware of. (Miller, n.d., para. 1)

Jean Baker Miller (1927–2006) is credited as initiating conversations within counseling and other disciplines that would lead to the eventual development of RCT (Hartling, 2008; U.S. National Library of Medicine, 2015). Miller was born to a working-class family in the Bronx, New York, a community in which women commonly worked outside the home to support their families. Miller was diagnosed with polio at 11 months old and faced significant physical challenges that required two medical operations, rehabilitation multiple times per week, and the use of leg braces. Throughout these experiences, Miller received ongoing support from her family and two nurses. Based on these connections, she aspired at an early age to enter a medical career and be able to support herself financially. As a child, she became a competitive swimmer and later was accepted to the Hunter College High School for Gifted Girls in Manhattan.

FIGURE 13.1 Jean Baker Miller

Miller's experiences at Hunter College High School were pivotal in solidifying her view about the importance of women's education (Hartling, 2008; U.S. National Library of Medicine, 2015). She received a scholarship to attend Sarah Lawrence College, where she received mentorship with the sociologist *Helen Merrell Lynd*, who introduced her to theorists within psychology and anthropology (e.g., *Margaret Mead*, *Erick Fromm*, *Harry Stack Sullivan*, and *Gregory Bateson*). After graduating from Sarah Lawrence College, she attended Columbia University with a full scholarship to become a psychiatrist. As she engaged in coursework, she became involved with student advocacy and social justice groups

and particularly focused on progressive healthcare policies. Miller's involvement with advocacy work was frowned upon, even drawing attention of the Federal Bureau of Investigations. She eventually lost her scholarship due to these activities yet persevered to complete her medical degree.

Miller completed her psychiatric residency at Bellevue Hospital and the Albert Einstein College of Medicine in New York City. During her residence, she married her partner, *S. "Mike" Miller*, a sociologist (Sturm, 2015). With nine months of her residency left, she experienced workplace discrimination when she was forced by hospital administration to resign when they discovered she was seven months pregnant. This experience crystallized for her the way women's work was devalued within society as compared to men. After finishing her residence and receiving her certificate in psychoanalysis from New York Medical College, she entered private practice in Manhattan and then became a faculty member at Harvard Medical School and Boston University School of Medicine.

During the 1970s, Miller became affiliated with feminist groups and met *Anne Bernays*, author and grandniece of *Sigmund Freud*. Bernays encouraged Miller to write her own book about psychology of women. In 1973, Miller published the edited book, *Psychoanalysis and Women*, which outlined several myths about the psychological lives of women.

Miller published her most well-known book, *Toward a New Psychology of Women*, in 1976. Borne from her clinical work with women, this book was largely a response to the often negative conceptualization of women by theorists such as Freud, *Erik Erikson*, and *Lawrence Kohlberg* (Bohecker et al., 2021). In this book, she proposed a new way of understanding women's psychological development and highlighted the ways in which psychology had failed to incorporate the unique experiences of women as well as the power imbalances in society between men and women. Furthermore, she noted the restricted view of Western culture that placed value on traditional masculine characteristics and devalued feminist and other cultural characteristics and contexts (U.S. National Library of Medicine, 2015).

The Founding Scholars group, originally known as the Stone Center Theory Group, included Miller and three other clinicians (i.e., *Judith Jordan*, *Irene Stiver*, and *Janet Surrey*) and began, in 1978, to eventually translate the concepts within Miller's (1976) book toward a new theoretical approach with women: RCT. They identified the importance of relationships and the desire to participate in the growth of others. Further, they suggested that both women and men were misrepresented in traditional theories, of which self-interest was viewed as a biological imperative (Jordan, 2017).

In 1981, Miller was appointed the Director of the Stone Center for Developmental Services and Studies at Wellesley College (Hartling, 2008; U.S. National Library of Medicine, 2015), which created a home and provided resources and colloquia for further knowledge construction in feminist and relational psychology. In 1986, she changed her professional role to Director of Education, which allowed her to focus on the creation of her theory, the relational model. The relational model, which focused on relational skills that women developed due to socially prescribed caregiver roles, challenged traditional models that separated relationships from development, viewed positive connection as necessary and critical to women's development, and believed that growth was supported through relationships with others. The importance of connection is highlighted in Miller's 1991 coauthored book, *Women's Growth in Connection* (Jordan et al., 1991).

In 1995, the Jean Baker Miller Training Institute (JBMTI) was founded at Wellesley College to explore the applications of the relational model; Miller was appointed director. In 1997, Miller and Stiver published *The Healing Connection* (Miller & Stiver, 1997) to expand the relational model. Concurrently, she worked with Jordan, Stiver, and Surrey to develop RCT, an extension of the original model that increased the focus on power in relationships (Hartling, 2008). Miller continued refining RCT and working as a psychiatrist and faculty member until 2006, when she died from respiratory failure and polio-related complications (Hartling, 2008). Miller was survived by her husband Mike; her two sons, *Jon* and *Ned*; and a grandson.

Over the years, Jean Baker Miller obtained numerous awards and honors, including honorary degrees, the Award for Outstanding Contributions to the Advancement of Psychology by the

Massachusetts Psychological Association, the Distinguished Career Award by the Association of Women in Psychology, the Ministry to Women Award by the Unitarian-Universalist Association National Women's Federation, the Woman of the Year Award by the National Organization of Women's Massachusetts Chapter, and more. She has clearly changed the way many women experience the therapeutic relationship (see Box 13.1).

BOX 13.1 Want to Meet Jean Baker Miller?

Want to hear a brief biography about Miller from the woman herself and find other tidbits of information about her? Go to https://silver.odu.edu/psyadm/ to see a caricature of Miller talking about herself and her theory. Click on the postmodern door, and go into Miller's office.

Feminist Theory and RCT

> So why is the sex barrier not taken as seriously as the racial one? The reasons are as pervasive as the air we breathe: because sexism is still confused with nature as racism once was; because anything that affects males is seen as more serious than anything that affects "only" the female half of the human race; because children are still raised mostly by women (to put it mildly), so men especially tend to feel they are regressing to childhood when dealing with a powerful woman; because racism stereotyped black men as more "masculine" for so long that some white men find their presence to be masculinity-affirming (as long as there aren't too many of them); and because there is still no "right" way to be a woman in public power without being considered a you-know-what. (Steinem, 2008, para. 6)

The above quote highlights the importance of feminist approaches to counseling and perhaps why there has been a sense of urgency to a greater focus on gender. RCT is a clear outgrowth of feminist theory, as the previous section on Miller and her work reflects.

Although the feminist movement can be traced back hundreds of years, modern-day feminism arose during the 1960s with such individuals like *Betty Friedan*, *Bella Abzug*, and *Gloria Steinem* (Brown, n.d.). Paralleling the civil rights movement and anti-Vietnam War protests, these women insisted that, like other oppressed groups, women's rights were equally important. Not long after the rise of modern-day feminism, several influential feminist scholars started to examine how women live in and understand the world, and not surprisingly, they suggested it was often not the same as the way that men did. Clearly, this placed many of the well-intentioned counseling theories, all created by White men, at odds with some of these new theories that implied that some of the values and ideas said to be inherent in the counseling relationship, were not particularly relevant to women. As men often do, they argued that point—but feminist philosophy and feminist therapy continued to grow and change over the years.

One of these early feminist scholars was *Sandra Lipsitz Bem*, who researched sex-biased job advertisements and women's recruitment in the workplace. In 1971 she developed the Bem Sex Role Inventory (BSRI), which looks at gender roles (how people fit into traditional sex roles) and classifies individuals as masculine, feminine, androgynous, or undifferentiated. For many feminists during the 1970s, androgyny (i.e., having men and women take on male and female qualities and roles) was an important goal, and for some, it continues to be (see Box 13.2).

BOX 13.2 Taking the Bem Sex Role Inventory

Do you consider your gender role identity to be more feminine, masculine, or androgynous? Two free online short-form versions of Bem's original Sex Role Inventory can be found at the following sites. It should only take you about 15 minutes to take one of them. If time allows, discuss your results with other students:

- https://www.psytoolkit.org/cgi-bin/3.4.0/survey?s=BsNnQ
- https://openpsychometrics.org/tests/OSRI/ (an inventory modeled after the Bem Sex Role Inventory)

Perhaps, the other most well-known feminist scholar of psychological theory has been *Carol Gilligan*. Her 1982 groundbreaking book, *In a Different Voice*, cast doubt on the generalizability of Kohlberg's developmental theory of morality, and second, it brought feminist critique of psychological theory to the forefront. Gilligan, who had worked with Kohlberg on his stages of moral development, suggested that whereas moral decision-making of boys and men tends to be logical and individualistic, women tend to be driven more by a *standard of care* and concern for others. She also noted that girls often lose their voice in middle school but gain it back again as adult women. *Difference feminism*, as her perspective has come to be called, highlights the different qualities between women and men but asserts that no value judgment can be placed upon them (different but not better or worse than). She also points out that psychology is integral to feminism:

> Feminism is one of the great liberation movements in human history. It is the movement to free democracy from patriarchy. In that sense, it's a movement to free everyone from the gender binary and the hierarchy of patriarchy in the interest of women and men, in the interest of love. It is a way of dealing with human conflicts other than through the use of force and the imposition of hierarchy ... Psychology is integral to a feminism that is defined in those terms. (Gilligan, as cited by Ball, 2010, para. 6)

Other feminist therapy scholars include *Laura Brown*, considered to be one of the pioneers of feminist therapy (Beaulieu, 2010; see Brown, n.d.); *Bonnie Burstow*, a radical feminist whose book, *Psychiatry and the Business of Madness*, challenges some of the very foundations of psychiatry; *Judith Worrell*, whose conversations with other women in psychology led her to advance the status of women in psychology and become active in shaping feminist therapy (MacKay, 2010); and *Judith Jordan*, the current Director of the Jean Baker Miller Training Institute at the Wellesley Centers for Women, whose books on feminist psychology and work on the relational–cultural model of development has made her one of the leaders of feminist psychology (Wellesley Centers for Women, 2022).

Although all of the women mentioned have impacted feminist approaches to counseling and psychotherapy, it was Miller, in collaboration with Stiver, Surrey, and Jordan, who created a group for women clinicians to share their thoughts on human growth and development, which eventually led to the development of relational–cultural therapy, sometimes known by its acronym RCT (Duffey & Trepal, 2016).

View of Human Nature

RCT is a *post-modern approach* to counseling that takes a *constructionist*, *humanistic*, *collectivist*, *relational*, *developmental*, and *feminist perspective* to understanding and working with clients (Jordan, 2000; Miller, 1976; Tucker, 2015).

As a postmodern approach, RCT does not believe in the notion that there is one reality and questions many of the so-called truths that mental health professionals have suggested are "real" (e.g., id, ego, superego, core beliefs, diagnosis, pathology, and collective unconscious). Along with many other postmodern approaches (e.g., narrative therapy and solution-focused brief therapy), RCT has a strong *social constructionist* flavor, which proposes that one's understanding of the world is distinctly impacted by the narratives in the social milieu to which the person has been exposed. This includes the person's family, culture, and society.

RCT is a humanistic approach because it has, at its core, the belief that through empathy and understanding one can come to understand the unique *phenomenological* perspective of the client. Being phenomenological, it views lived experiences as unique to the individual and seeks to not judge clients' realities. Thus, there is no one reality but multiple realities, which are based on the clients' understanding of the world.

RCT is a collectivist approach because it values the connection that individuals have with others, particularly how women tend to relate with other women. Thus, the broader community of people is critical to the development of the *relational self*—or how individuals come to understand who they are. The relational self can be negatively impacted if a client is in an abusive relationship but positively impacted if a client is in a positive, supportive relationship, as should be found in the counseling relationship. RCT believes that individuals have a *natural disposition toward relationship and connection*, although some relationships can thwart growth.

When creating RCT, Miller conceptualized the human experience as relational and recognized that caregiving was a historically significant component of the lived experiences of women (Miller, 1976). Up to that point in time, typical theories of counseling and psychotherapy, created almost exclusively by White men, evolved around the White male experience (Jones-Smith, 2021; Tucker, 2015). In juxtaposition to preexisting theories of psychology of human development, which centered on self (in contrast to self in relation to others), competition, aggression, and destruction, Miller sought to express the psychological experiences of women through their role and work as caregivers and relational beings. RCT and other feminist approaches posit a view that society's expectations of gender are a *social construct* and that human experiences are neither male nor female but *androgynous* (Jones-Smith, 2021; Miller, 1976). Miller (1976) explained her work as a "look toward a more accurate understanding of women's psychology as it arises out of women's life experience rather than as it has been perceived by those who do not have that experience" (p. 49). From RCT, a wide range of gender-focused therapeutic theories and modalities have evolved and emerged, supported by the work of various scholars and therapists.

RCT believes that development occurs throughout one's lifespan and interwoven with the growth of relationships within which individuals find themselves. Individual and relational growth is not viewed occurring at specific points in time but occur as relationships become more complex and increase in depth (Jordan, 2018). Since growth can occur at any point in one's life, the approach is seen as *antideterministic*.

In addition to the relational and developmental focus, RCT has a commitment to distinct *feminist values*, which sets this therapy apart from other approaches (Frey, 2013; Tucker, 2015). Feminist values include the characteristics of being nonsexist, engaging in critical discourse regarding sociocultural issues, and exploring how sociopolitical issues impact women and other nonprivileged gender identities. RCT posits that gender, gender roles, identity, and even pathology are social constructs that are shaped by sociopolitical forces, such as sexism, racism, heterosexism, power, and privilege. These social constructs, and how they impact clients, should be explored in the therapeutic process.

Miller believed that gender role socialization led boys and girls to develop *binary gender roles*, which encourages the development of "womanly" feelings and behaviors in women (e.g., expression of "softer" feelings, nurturing behaviors, and desire for connection) and "manly" feelings and behaviors in men (e.g., competition, anger, and decisive behaviors; Miller, 1976). Because we live in a patriarchal society, womanly feelings and behaviors tend to be shunned and, in their extreme, pathologized by many traditional counseling theories. Thus, by default if one is a woman, one is likely to be considered psychologically inferior:

> Today in psychotherapy a central piece is given to feelings of weakness, vulnerability, and helplessness, along with their usual accompaniment, feelings of neediness ... Such feelings are of course, most unpleasant—in their extreme, they are terrifying—and several schools of psychodynamic thought postulate that they are the root causes of various major "pathologies." (Miller, 1976, p. 29)

RCT sought to change the way women are viewed by uplifting women and depathologizing those behaviors that were traditionally seen as negative. In addition, it sought to help women embrace their natural tendency for connection to others, so often defined as weakness, dependency, or an inability to be autonomous.

Key Concepts

RCT is grounded in *eight principles*, all of which are related to relational competence (Jordan, 2018, pp. 28–29):

- People grow through and toward relationships throughout the lifespan.
- Movement toward mutuality, rather than movement toward separation, characterizes mature functioning.
- Relational differentiation and elaboration characterize growth.
- Mutual empathy and mutual empowerment are at the core of growth-fostering relationships.
- Authenticity is necessary for real engagement and full participation in growth-fostering relationships.
- In growth-fostering relationships, all people contribute and grow or benefit. Development is not a way one-way street.
- Development of increased relational competence and capacities over the lifespan is a goal.
- Mutual empathy is the primary means from which we grow.

Following these principles results in what Miller called *five good things* (Jordan, 2018; Miller & Stiver, 1997): (a) *increased sense of zest* or feeling of energy and well-being; (b) *empowerment to act*, or the motivation to take action in a relationship; (c) *clarity/knowledge of self and others*, which refers to increased understanding of oneself and others in relationships; (d) *self-worth*, or an increased value of self in relation to others; and (e) *desire for more connection*, or the feeling of greater connection that leads to a desire to connect with others. Let's take a closer look at these eight principles.

1. People Grow Through and Toward Relationships Throughout the Lifespan

Whereas other theories of counseling and psychotherapy present growth and development as an internal drive focused almost solely on the individual, a central tenet of RCT is that human beings exist to form relationships and that individuals grow through and within relationships (Jordan, 2018; Miller, 1976). This is described by Miller (1076) as the *self-in-relation model*. Thus, the self does not exist in a vacuum; it only exists in relation to others, is contextual, and is determined by past, present, and future relational experiences. RCT is particularly concerned about how relational experiences "woven through a patriarchal culture" may negatively impact women (Robbins, 1985, p. 22).

Early relationships are especially informative in RCT and influence social, cognitive, and moral development (Jordan, 2018). An individual's early relationships establish *relational images*, which serve as a template or model across one's lifespan (Miller & Stiver, 1995). Thus, they guide how individuals think of themselves and others and influence strategies for relationship engagement (or disengagement; Brown et al., 2018; Jordan, 2000, 2018). For example, a young girl may learn about gender roles from her parents' relationship; this girl's relational images of marriage and gender roles subsequently provide a model for her conceptualization of gender and marital roles in lives. However, these models can change as she becomes involved in new relationships over her lifespan. Relational images grow throughout our lives to either promote relational competency or increase isolation, shame, and disconnection. Thus, RCT suggests that any relational changes will impact growth, and that is why mutual growth through healthy relationships, such as a relationship that is formed through RCT, is highlighted in this approach.

2. Movement Toward Mutuality, Rather Than Movement Toward Separation, Characterizes Mature Functioning

Individual psychological growth is predicated on authentically experiencing and engaging in positive relationships with others. Because growth is relational, increasing and deepening existing relational connections indicates healthy socio-emotional functioning (Jordan, 2000). Whereas health is highlighted through mutuality and depth in relationships, pathology has *disconnection* at its core and is viewed as the cause of maladaptive behaviors. *Connection* is the ultimate goal of mature human development, and chronic *disconnection* is the source of dysfunction. Disconnection occurs when the client is prevented in participating in mutually responsive and growth-enhancing relationships (Jordan, 2018). Jordan (2017) notes that disconnections are inevitable; what matters is how we respond to them. As clients identify and address disconnection, a fear of rejection and other vulnerabilities is natural. As such, the counselor must validate these feelings.

RCT believes that even though humans have a natural disposition toward relationship and connection, they can behave in ways that inhibit their own ability to connect with others (Jordan, 2018; Miller, 1976). Called *strategies of disconnection*, these are the unique ways (e.g., isolation and silencing) that individuals increase and/or maintain social and emotional distance to avoid pain and hurt. Such disconnection is related to the relational images one has developed over time (Jordan, 2018). Thus, if historically an individual has experienced abuse when in a close relationship (e.g., parents), that person may consciously or unconsciously develop strategies that paradoxically prevent such closeness in many or even all future relationships, even ones that could be potentially healthy.

The ultimate goal of RCT is the development of new, mature relationships, where closeness can be tolerated as the individual builds depth and maturity with the counselor and, ultimately, with others who can also foster a growth-enhancing relationship. For historically oppressed groups, lack of power, privilege, and access shape relational images in a manner that can lead to a sense of disconnection from the dominant group (Jordan, 2018). Socially sanctioned discrimination and oppression (e.g., racism, sexism, heterosexism, and ableism) can cause an individual to maintain distance consciously or unconsciously from the dominant culture. Called the *cultural-relational paradox*, a client's lack of power and privilege can result in marginalization, expressed by chronic loss, isolation, and a sense of disconnection from some social networks and institutions (Jordan, 2000; Miller & Stiver, 1997).

3. Relational Differentiation and Elaboration Characterize Growth

In RCT, the ability of individuals to differentiate their identity, while maintaining relational connection characterizes growth. Thus, when individuals are in a relationship, their ability to grow and learn from each other is a mark of maturity and is underscored by each individual's changing and expanding identity (Jordan, 2018).

RCT recognizes that relational growth and change are not easy tasks to manage, as relational conflict is inevitable, and disagreement and challenges are natural. From a RCT perspective, conflict is not viewed as negative or positive; however, the ability to address disagreements in a positive manner is an important indication of growth (Jordan, 2018). If placed in a caring, mutually growth enhancing environment, individuals have the capacity to move toward conflict and resolve it, as opposed to separating oneself from it and disconnecting from the other. Thus, the ability to successfully engage in conflict resolution is an important milestone in RCT and a critical aspect of mature and developing relationships (Jordan, 2018).

4. Mutual Empathy and Mutual Empowerment Are at the Core of Growth-Fostering Relationships

Working toward healthy, mature, growth-fostering relationships is at the center of how RCT describes healthy interpersonal functioning, and such relationships are highlighted by mutual empowerment and mutual empathy (Jordan, 2018; Miller, 1976; Sturm, 2015). Mutual empowerment is the two-way process of caring and supporting others' strengths, whether it be in a therapeutic, love, or friendship relationship. Such mutual empowerment allows each individual within the relationship the "capacity to be moved by, respond to, and move the other" (Mencher, 1997, p. 323). This mutuality that occurs in relationships demonstrates mutual empowerment and mutual empathy and contribute to the growth of the other in meaningful ways (Jordan, 2017, 2018).

5. Authenticity Is Necessary for Real Engagement and Full Participation in Growth-Fostering Relationships

Core to therapeutic engagement is the notion that the counselor is real or genuine with clients (Miller, 1976; Tucker, 2015). As opposed to some other approaches, particularly psychodynamic and some cognitive-behavioral approaches, the relational–cultural therapist is not seen as the "expert" but as a collaborator with the client. Much like narrative therapy and solution-focused behavior therapy, the relational–cultural therapist approaches the client with respect, curiosity, and as an equal. As in person-centered counseling, genuineness or authenticity is key to the development of relationships and to the expression of empathy and is limited by the boundaries inherent to the counseling relationship. In addition to the expectations of empathy toward and for the client, the expectation is that through building a genuine relationship, the client will have *mutual empathy* toward their counselor.

6. In Growth-Fostering Relationships, All People Contribute and Grow or Benefit: Development Is Not a One-Way Street

The importance of mutuality in RCT is grounded in the theory's understanding of gender relations, discourse, and patriarchy. Being in relationships, and caring for others, is a part of the human experience; yet caregiving roles and work are sometimes viewed exclusively as a woman's activity, go unrecognized, and are often grossly undervalued (Miller, 1976). In fact, women have historically been the primary caregivers in society (e.g., mothers, nannies, nurses, teachers, social workers, and counselors), and they demonstrate this by being caring to others, by being nurturing, through their use of empathy, and by being willing to respond to the needs of others. However, they have often found themselves in relationships that are one-sided, where the woman is expected to engage in a majority of the emotional and even physical labor within the relationship. RCT states that women, and all persons, should seek to create two-sided, mutually growth-fostering relationships that are highlighted by ongoing positive changes in the relationship and a continual broadening and deepening of individuals' identities (Mencher, 1997; Miller, 1976).

7. Development of Increased Relational Competence and Capacities Over the Lifespan is a Goal

When RCT works effectively, counselor and client come to a relational consensus where they work together to achieve common goals within a two-way growth fostering process (Miller, 1976; Surrey, 1997). That is, therapy relationships are characterized by a special kind of mutuality. Early

on, counselors may hold more responsibility or power; however, it is expected that quickly, and throughout most of the therapeutic process, clients will assume an increasing amount responsibility for the relationship.

Awareness of how the counselor and client respond to one another can lead to clients altering their relational expectations and creating opportunities for the client to develop a connection with the counselor and, ultimately, with others (Crumb & Haskins, 2017). Through the counseling relationship, counselors empower clients to become more relationally competent, in which they become aware of the impact of others on them, their impact on others, as well as the value of vulnerability in creating an opportunity for personal and interpersonal growth (Jordan, 2000, 2018; Sackett & Jenkins, 2019).

Within the therapeutic context, mutuality is achieved by the therapist's ability to be "empathically attuned, emotionally responsive, authentically present, and open to change" (Surrey, 1997, p. 43). It is also highlighted by the counselor's ability to being conflict friendly, being able to openly discuss issues with the client, and periodically inviting the client to openly discuss concerns and issues with the counselor (Feminist Therapy Institute, 1999). In addition, embracing and being committed to feminist values, such as gender issues, racial inequality, oppression, and intersectionality, enhances the relationship, as client and counselor find common concerns to discuss (Frey, 2013; Surrey, 1997).

8. Mutual Empathy Is the Primary Means From Which We Grow

As already alluded to, empathy is a powerful tool in RCT because when clients feel understood, they are more likely to explore their lived experiences, including those they have experienced in relation to socio–political contexts and prescribed gender roles (Frey, 2014; Jordan, 2018; Miller, 1976). Foundational to empathy is being authentic and creating a warm and accepting therapeutic environment. The therapeutic relationship is the vehicle through which clients can experience growth-producing relationships, with skills that can be applied to current and future external relationships. Thus, counseling can serve as a corrective relationship in which clients move out of isolation and disconnection to feel more accepted and valued by themselves and others (Jordan, 2000, 2018).

Authenticity, acceptance, and demonstrating empathy allows the relationship to progress, enables clients to become increasingly vulnerable, helps them understand how their gender roles have been impacted by the social milieu and, more generally, helps them be clear about who they are and their life situation. As counselors model a caring attitude, acceptance, and empathy, clients increasingly become more adept at demonstrating these same skills and the relationship becomes increasingly mutual—where both the client and counselor can learn from one another (Tucker, 2015). Building a growth-fostering counseling relationship, through the use of empathy and related skills, can assist clients in developing new and more positive relationships outside of counseling—relationships that can be sources of personal empowerment and resilience (Flores & Sheely-Moore, 2020).

Therapeutic Techniques

RCT employs specific therapeutic styles and strategies to achieve therapeutic goals and to increase client well-being (Jordan, 2001, 2018; Miller, 1976). Counseling allows for a space to deconstruct and reconstruct relational images, enhancing relational resilience by resisting disconnection, making meaning from connections and disconnections, and examining the role of power in client's lives (Crumb & Haskins, 2017; Jordan, 2018). To accomplish this, the skills and techniques used in RCT are focused on building an equal and trusting relationship with clients; helping clients

gain awareness about family, cultural and societal pressures that have negatively impacted them; fostering the development of a new identity and sense of self; and encouraging clients to develop growth-enhancing and empowering relationships with friends, lovers, and significant others.

Some of the primary skills used to foster a growth producing counseling relationship include respecting the client, showing curiosity and wonder, being nonpathologizing, and demystifying the counseling relationship; demonstrating acceptance, authenticity, and empathy; analyzing counselor–client power differentials; encouraging discussion about oppression and marginalization; encouraging empowerment, high self-esteem, assertiveness, and emotional identification and expression; and asking questions about the client's life (Miller, 1976; Tucker, 2015).

Respecting the Client, Showing Curiosity and Wonder, Being Nonpathologizing, and Demystifying the Counseling Relationship

From the moment the therapeutic relationship begins, the relational–cultural therapist honors and respects the client by demonstrating a sense of appreciation for the unique path the client has taken and will take in life (Gold, 2008; Jansson, 2020). Clients are not viewed from a pathological perspective, are not given diagnostic labels, and are not considered to be "resistant" or "difficult" (Pickersgill, 2013). Instead, strengths are highlighted, and positive qualities are noted. In addition, the counselor does not create an artificial sense of professional distance from the client. Instead, counselors see themselves, and present themselves, as equal partners with their clients within the helping relationship (Harrison, 2013). This is communicated verbally and nonverbally to the client when the counselor uses respectful communication, shows curiosity and wonder about the client's situation, and is honest about the purpose and goals of the therapeutic relationship.

Demonstrating Acceptance, Authenticity, and Empathy

> The need for supporting core self-esteem doesn't end in childhood. Adults still need "unconditional" love from family, friends, life partners, animals, perhaps even an all-forgiving deity. Love that says: "no matter how the world may judge you, I love you for yourself." (Steinem, 1992, p. 66)

Key to building a therapeutic relationship is the ability to demonstrate acceptance, authenticity, and empathy (Jordan, 2001; Miller, 1976). Relational–cultural therapists show unconditional love and acceptance to their clients; however, clients may present themselves; are able to effectively reflect both the affect and meaning of the client's experience; and are real with clients, within the limits of the therapeutic relationship. Such realness attempts to lessen what is often perceived as distance between the counselor and client, as the counselor attempts to defuse power differentials within the relationship.

Analyzing Counselor–Client Power Differentials

> Power exists and has to be taken account for; it cannot be denied. (Miller, 1976, p. 5)

After initial rapport is built, counselors are encouraged to analyze power dynamics within the counseling relationship and discuss those dynamics with the client (Jordan, 2001; Miller, 1976). Discussion around how clients perceive and are impacted by the counselor and how counselors perceive and are impacted by their clients can occur in an effort to delimit power and equalize the relationship (Sackett & Jenkins, 2019). Such mutual discussions regarding how power is used in

relationships can be generalized to power issues within the client's life and, ultimately, broader social justice and advocacy issues.

Encouraging Discussion About Oppression and Marginalization

Once a strong relational foundation is established, clients or counselors can initiate a dialogue about clients' experiences of oppression and marginalization as it relates to their individual identity statuses and their intersectionality (e.g., race/ethnicity, gender identity, sexual orientation, and age; Butler, 1985; Crenshaw, 2017; MacKinnon, 2013; Miller, 1976). Such a discourse helps clients understand how minority status, culture, power, and privilege have impacted their identity and their relationships with others. Within the original conceptualization of RCT, such discussions would solely have focused upon the client's experience of being a woman in relation to a patriarchal culture. However, today, such discussions can be utilized with any client, of any gender, about any and all client identity statuses and can focus on a number of oppressive systems. Since oppressive systems lead to a sense of isolation and disengagement from self and others, the goal of this discourse is "to lessen the experience of condemned isolation in the therapy relationship in order to help clients transform their lives outside of therapy" (Jordan, 2018, p. 41).

Encouraging Empowerment, High Self-Esteem, Assertiveness, and Emotional Identification and Expression

After framing the counseling sessions within the context of sociopolitical discourse, relational–cultural practitioners help clients deconstruct their identities, which have been partly based on a development of self within oppressive systems. Next, they help them develop new identities based on a new lived experience of self (Jordan, 2018). This can be done through a variety of therapeutic techniques, such as encouraging empowerment, high self-esteem, assertiveness, and emotional identification and expression training (Burtle, 1985; Jordan, 2001, 2018; Miller, 1976; Stere, 1985; Weiss, 1985).

Encouraging Empowerment

Client empowerment is achieved by assisting individuals who are not traditionally deemed close to power (e.g., women) gain awareness of power that they already possess (Jordan, 2018; Miller 1976). This would include specific exploration with clients of their own strengths and areas in their lives where they do feel empowered, encouraging them to increase moments and situations of empowerment, and helping them to increase overall power and autonomy in their lives. A part of the empowerment process may include a variety of specific interventions that focus on examining existing areas of power and developing new areas of power (e.g., assertiveness training; Gerhart, 2016; Reynolds, 2010).

Encouraging High Self-Esteem

Traditionally, women's self-esteem has often been influenced by external factors, such as societal "rules" about beauty and gender roles (being a "good mother" and "wife," acting "feminine," and so forth; Jordan, 2018). Some of the work that takes place in therapy is the understanding that women can set their own expectations about the roles they take on in life and that they don't need to be held to external norms and pressures. Such awareness generally increases clients' sense of self-worth, as they realize they have been held to unrealistically high external standards and can develop their own sense of who they are and what they want to become. Self-esteem work can

empower clients to feel more positive about their bodies, their experiences, their skills, and their overall self-worth and is especially important with clients who are feeling sociocultural pressure to perform to stereotypical societal norms.

Encouraging Assertiveness

> Women often have a smaller range of acceptable behaviors ... than men. If they are too nice, they are seen as weak or manipulative. If they are too aggressive, they are judged as acting like men or typical bitches. (Reynolds, 2010, p. 1)

Expectations of women, based on covert and sometimes overt cultural norms and societal rules, are that they do not speak out or strongly assert their opinions. This results in many women feeling as if they do not have a voice, or a say, in their lives. One way for women to bolster their sense of self is to learn how to assert themselves (Gerhart, 2016; Stere, 1985). Assertive (as opposed to aggressive) individuals (a) know how to be passionate about their points of view yet can allow others to disagree, (b) can understand other people's perspective and can help find common ground among differing points of view, (c) will choose to inspire people as opposed to rebel against people (e.g., using positive, not antagonistic, language when expressing their points of view), and (d) can diplomatically stand their ground and feel comfortable within themselves when others sharply disagree or try to intimidate them due to differing beliefs (Reynolds, 2010).

By helping clients understand the gender roles that are lived out by women, relational–cultural therapists can help women understand the pressures that have led them to be nonassertive in a patriarchal society. With this knowledge, counselors can teach clients the steps to use to become more assertive while modeling assertive behaviors themselves.

Encouraging Emotional Identification and Expression

Whereas men tend to be more comfortable with anger, competitiveness, decisiveness, and decision-making, women tend to be more at home with empathy, nurturing, caring, and the expression of many sad feelings (Burtle, 1985; Reynolds, 2010). Empowering clients to identify and express the spectrum of their emotions and underscoring the idea that all emotions are valid is a component of RCT and feminist counseling work. Relational–cultural therapists encourage the full range of emotions by showing client acceptance and being empathic, which allows clients to acknowledge feelings they may not have felt comfortable admitting to themselves (see Box 13.3).

BOX 13.3 The Case of Illanna

It is not atypical to have female clients, who, after weeks or even months of therapy, suddenly uncover their identity, which may include feelings that have not been voiced by them in the past. For instance, Illanna, a female client, who presented with generalized anxiety, talked in vague and generalized terms about her anxiety for months. After months of the counselor demonstrating acceptance and empathy, Illanna slowly began to understand that she was in a verbally abusive marriage and was extremely angry at her husband. As she accepted all her feelings in her life—including her anger—she was able to confront her husband about how he was treating her. Slowly, Illanna, began to redefine her sense of self as an assertive woman who is allowed to have her unique feelings. This was the first step toward a mutual relationship or to dissolution of the relationship if her spouse is not able to allow Illanna to embrace her newfound identity.

Asking Questions About the Client's Life

To help clients understand how family, cultural, and societal messages about gender and other cultural roles have impacted their lives, it is important to inquire about the clients' lives through the use of questions. Authentic engagement, through thoughtful questions, can serve as a primary step toward connection and reconnection. We provide the following list as example questions for counseling sessions:

- What are some of the most significant relationships in your life?
- What are your observations about yourself and your relationships?
- What do you value about relationships?
- Where did you learn messages about relationships?
- How do you approach relationships?
- Tell me about the relationships you have made within [setting].
- To whom do you turn for support of strength?
- Describe your relationship with _____.
- How do experiences as a [cultural identity] impact your relationships?
- What gender roles did your mother and father model for you?
- How did you parents' gender roles impact you?
- Did your siblings impact the way you view gender roles?
- What messages did you get at school and in your community about the gender roles you should live out?
- What significant people in your life did you model after?
- Relative to the roles you have played out in your relationships and in your career, do they seem to reflect what you wanted in your life?
- If your life was to be different, how would it look?

Questions, such as the above ones, tend to be open-ended and focused on how family, culture, and society may have impacted clients' lives and formed relational images. They can help to open the discussion around understanding how oppression and marginalization have impacted clients' lives.

The Counseling Process

The therapeutic process in RCT is driven by *eight guidelines of the therapeutic process*, which include the following (Burnes et al., 2010; Enns, 2003; Harper et al., 2013; Kilman, 2013; MacKinnon, 2013; Miller, 1976; Tucker, 2015):

1. **Recognize the harmful effects of a patriarchal culture.** Make sure issues related to oppression due to gender roles and patriarchy are addressed. In particular, help clients understand that a patriarchal society has often resulted in women feeling "less than."
2. **Explore inherent contradictions in prescribed gender roles.** Help women understand conflicting roles and how to identity which roles are best for them. As women come to such personal realizations, they may have important choices to make, such as, "Is this a career I really want to go into?" "Do I want to have children?" "Do I want to be a stay-at-home mother, or would I rather work?" "What roles do I want to take on in a marriage?" and so forth.
3. **Support clients in the exploration of their inner resources.** Help women examine their personal strengths, resiliency, and ways of coping that have allowed them to navigate systems of oppression or marginalization.

4. **Integrate other therapeutic modalities into the RCT approach.** Although RCT offers a general direction of how to practice, specific techniques from other approaches may be useful when working with women and should be incorporated.
5. **Demystify the power relationship inherent in any therapeutic relationship.** Counselors do not hold ultimate answers to client problems and should not act as experts. Through respect, curiosity, acceptance, empathy, education, self-disclosure, and questions counselors should offer a growth-fostering relationship in which clients feel like equals and can explore their identities and make new, deeper, connections with others.
6. **Match women clients with women therapists.** Women often understand the experience of other women best, thus RCT should often be conducted by a female therapist (Butler, 1985). However, with changing gender roles, RCT with some men and some transgender individuals may also be effective.
7. **Conduct ongoing evaluations of practice.** Continually reflect on one's philosophy of feminism, including beliefs about diverse groups and emergent social justice issues, and evaluate one's practice setting to ensure equitable and accessible services to all.
8. **Therapy is not a cure-all.** Although the therapeutic relationship can be one component of developing healthier ways of being, other positive, self-enhancing activities should also be explored by clients.

With the eight guidelines just noted woven through the therapeutic process, RCT can be viewed as a series of phases that parallel the emergence of the techniques just discussed. When clients initially enter therapy, they are often unaware of the sociocultural pressures that have impacted their understanding of the world and their development of self. Initially, clients are invited into therapy through the counselor's use of respect, by their desire to show curiosity and wonder, by being nonpathologizing, and by demystifying the counseling relationship. Then, as the counselor demonstrates empathy and acceptance, clients slowly begin to realize how they have been marginalized by gender and cultural roles. At the same time, emergence of underlying feelings that have been submerged because of the prescribed and often oppressive gender and cultural roles they have taken on become recognized.

While acceptance and being empathic with clients is critical near the beginning of the relationship, so is the analysis of counselor–client power differentials (Mencher, 1997; Miller, 1976; Surrey, 1997). Although some power differential is natural at the beginning of a therapeutic relationship, ultimately counselors attempt to lessen this differential early on, and this is done by having discussions about the relationship and by having the counselor not act as an objective expert with the client, as is so common in many therapies. Instead, the counselor defines the relationship as a mutual journey, through which both the counselor and client can grow and learn from one another. Thus, there becomes a sense of fluid expertise, where both the counselor and client hold unique knowledge and understanding (Jordan, 2017).

As the relationship continues, the counselor encourages discussion about oppression and marginalization, so clients can better understand how their identity statuses (e.g., race/ethnicity, gender, sexual orientation, and age) have impacted their sense of self. It is then that clients will realize that their lack of power and privilege has led to feelings of oppression, a sense of marginalization, and disconnection and isolation from self, from others, and from society. Here, the use of questions may be used to help clients explore how their family, culture, and society may have impacted their sense of self.

After the realization that clients have lived inauthentically in prescribed societal roles, they are ready for the next phase of therapy—the development of a new identity. This occurs by helping clients identify aspects of self in which they have already felt empowered and by helping them

find new ways to empower themselves; by helping them identify their own sense of who they are, rather than buying into external definition of self; by encouraging new assertive behaviors, where clients can feel increasingly comfortable living out their newfound identity; and by encouraging clients to be in touch with and express a full range of their emotions and not be bound by cultural and societal prescriptive roles.

Therapy nears its conclusion when clients have developed a new sense of self, feel more like an equal with the counselor, have likely developed new friendships that reinforce their new sense of self, and are willing and able to engage in ongoing constructive and healthy discussions with others with whom they are in a relationship (Mencher, 1997; Miller, 1976; Surrey, 1997; see Box 13.4).

BOX 13.4 The Case of Julie

Julie, a 35-year-old woman, came to counseling due to feelings of depression and generalized anxiety. At first, she was not aware of why she had these feelings. Her counselor, Kristina, began counseling by being empathic, accepting, and respectful. She was also curious about Julie's situation and wanted to hear all of what she had to say. In addition, she did not act like an expert and did not treat her like she was ill.

Over time, Julie began to realize that her depression and anxiety were partly the result of feeling trapped in a verbally abusive relationship, even though she was a high achieving business woman and could easily live on her own. At that point, the counselor began to ask Julie about the kinds of messages she had received growing up about marriage and career. Julie noted that although she was reinforced for being a career woman, she remembers being continually told that a wife should honor her spouse and respect his wishes. She felt like her parents said this to her nonverbally and that most of her friends believed this. She also realized that she had received past messages that subtly, but powerfully, told her she should not stand up to her husband, that she "must" be in a relationship to be a successful woman, and that she needs a man to be "whole." After helping Julie understand these messages and helping her see the many strengths she possessed, she realized how resilient she had been and how she has "put up" with an abusive husband.

As Julie continued in therapy, she realized that her marriage was not a life-enhancing relationship and that, for the most part, she was being "pushed around" in the marriage. She realized her "voice" was not being heard, and she is beginning to just now understand who she really is and what she really likes. With this newfound awareness, Julie decided to confront her husband. Initially, he became increasingly verbally abusive, but over time, when he realized she was serious about how she felt and that she might leave the relationship, he began to show some attempts to listen to her.

Meanwhile, through a therapy group, Julie has begun to connect with other women who have had similar experiences, and she is realizing that for much of her life she did things to please others. She realizes that, on the one hand, she likes taking care of others, but on the other hand, she also would like a relationship that is mutually enhancing. She is thinking that she would like to try marital counseling but is also wondering if she should leave the relationship altogether. She knows that either will be a big decision and has begun to discuss this with Kristina. At this point, the discussions are around whether Julie believes her husband can have a mutually life-enhancing relationship.

Julie's relationship with her counselor feels life-enhancing, as she increasingly builds a mutually empathic and respectful relationship with Kristina. This relationship is modeling what all relationships can be, and Julie is hopeful that future relationships, whether or not they include her husband, will be like the one she has developed with Kristina.

Social, Cultural, and Spiritual Issues

Due to its focus on, power, privilege, oppression, and marginalization, in recent years RCT has been found to be applicable to a variety of diverse populations, not just women (Brown et al., 2018; Hall et al., 2014; Jordan, 2017; Singh & Moss, 2016; Sackett & Jenkins, 2019). In particular, RCT's examination of the social, cultural, and spiritual factors that have led to a sense of disconnection and marginalization are important goals for all culturally diverse clientele.

Disconnection in relationships can occur when there are real or perceived experiences of exclusion, invalidation, and/or microaggressions (Jordan, 2018). These disconnections can diminish growth and wellness for the individual, especially when power differentials are involved. Disconnection can arise from systemic oppression; can be acute, chronic, or traumatic; can minimize cultural identity expression and, thus, hinder authenticity in a person's life; and can lead to isolation from others, groups, and society (Comstock et al., 2008; Jordan, 2018). Counselors can discuss with clients how disconnection and isolation are survival mechanisms for clients of marginalized statuses (Brown et al., 2018). In addition, counselors can encourage and brainstorm with clients ways they can find healthy social and community ties and connection with others and help them move from strategies of disconnection (e.g., blame, isolation, withdrawal, and lying) to those of connection (e.g., authenticity, empathy, and active listening) with others who are capable of mutually empathy and empowerment.

The heart of successful therapeutic outcome is fostering a positive therapeutic alliance (Wampold, 2015). In RCT, the relationship, which is based on mutual empathy and empowerment, is core to successful outcomes and helps the client explore power dynamics in their lives and helps them advocate for themselves and others (Sackett & Jenkins, 2019). In addition, relational–cultural therapists can create communities to disrupt systemic injustice and nonrelational structures that contribute to disconnection and isolation. In RCT, the client also impacts the counselor, whose multicultural counseling and social justice competency grows because of mutual empathy and mutual empowerment.

With its attention to *power*, *privilege*, and *oppression*, additional frameworks, such as *critical race theory* (CRT) and *intersectional theory*, are helpful to consider and integrate into RCT when counseling diverse clients. CRT offers a framework that counters traditional counseling theories that have not adequately addressed the mental health needs and resiliencies of people of color (Singh et al., 2020). Originating from *Derek Bell*, within the law discipline, to call attention to racial inequities of Black men who are incarcerated (Bell, 1995), CRT helps counselors understand how racial injustice impacts clients and the counseling relationship.

Haskins and Singh (2015) applied CRT to counseling and noted the following tenets. First, race and racism are permanent and intersectional, infiltrating all societal systems, including the counseling practice. Second, color blindness and liberalism minimize the role that racism actually does have on individuals. Third, racial equity results only when there is interest convergence—that is, when White people and people of color gain from it. Fourth, the promotion of counter-storytelling acknowledges that people of color have stories that counter those told from the vantage of Whiteness, which tends to highlight race as neutral, promote color blindness, or portray negative images of people of color. The relational–cultural therapist employing CRT explicitly attends to the client's racial identity and experiences with racism, examines how those identity and experiences link to their connections and reconnections, and facilitates the client in developing counternarratives and mutual empathy, installing positive relational images, and developing connections with others.

Kimberlé Crenshaw (1991) coined the term *intersectionality* to highlight the differential experiences of Black women as compared with Black individuals in general or women as independent identities. Crenshaw (1991, 2015) highlighted the fact that individuals experience discrimination multidimensionally, and multiple systems of oppression intersect to perpetuate individual and societal discrimination. In contrast to most other theories of counseling, RCT has a focus on understanding and unpacking clients' intersectional experiences of gender, race/ethnicity, sexual identity, social class, ability status, religion, spirituality, socioeconomic status, age, and other unique identity factors (see Box 13.5).

BOX 13.5 The Case of Geraldo

Flores and Sheely-Moore (2020) applied RCT to work with LGBTQ college students. In a case application of RCT, they use an example of a college student exploring coming-out issues with a bisexual college man. Geraldo, a 20-year-old first-generation Mexican American, lives in campus housing in a city within the Southwestern United States. His counselor is Jane, a 45-year-old White, heterosexual, cisgender women, who has worked at the university counseling center for 10 years.

During the initial phase of counseling with Geraldo, Jane inquired about identities salient to him and which pronouns he used. These conversations reflected Jane's willingness to broach conversations about culture, while not making assumptions about Geraldo's sexual and gender identities. Geraldo disclosed his struggles with coming out as a bisexual man to his family members, due to their conservative religious views.

Jane co-constructed an eco-web with Geraldo to highlight connections and disconnections. As Geraldo described significant relationships within his life and sources of support, he disclosed a positive relationship with a Calculus III professor and mentor, Dr. Porto. In terms of disconnections, Geraldo noted distance and limited communication and infrequent visits to his parents as well as limited relationships with others in the campus community. Through the eco-web activity, Jane identified three themes: emotional distance from his parents; withdrawal from school peers and the campus community; and disconnection from his authentic self as a bisexual man. After these themes were identified, Jane revisited sources of connection within the campus community that Geraldo may not have readily identified during eco-webbing (i.e., developing a visual representation of connections and social supports; see Williams et al., 2015). Geraldo, then, identified two campus relationships (with a residence hall director and a department secretary) and reflected upon what aspects of these two individuals allowed him comfort to develop positive relationships.

Next, Jane explored Geraldo's internalized shame of identifying as a bisexual man and the potential link of that shame to his religious upbringing. As he spoke of his childhood experiences at home and in the church community, Jane noted several aspects of his negative self-worth, along with his inability to readily identify personal strengths. To address internalized shame, Jane helped Geraldo to identify ways in which he has been resilient as an academically successful, first-generation college student, despite the oppressive experiences he faced as a bisexual man. Highlighting discrepancies between his negative internal schemata and external evidence of personal strengths helped deconstruct these schemata and challenge him to consider how he could challenge negative internal schemata on his own outside of the counseling relationship. She then implored him to brainstorm ways in which his bisexual identity could be an asset for him to forge campus relationships with other LGBTQ individuals. This brainstorming allowed him to shift from disconnection experiences to increased connection.

Throughout counseling and because of an egalitarian and trusting counseling relationship, Geraldo was able to reformulate how his bisexual identity is a potential strength, one which did not limit his ability to form positive relationships, similar to the one he was able to form with Jane. In addition, Geraldo attended a local church that was receptive to the LGBTQ community, which allowed him further support to affirm his identity as a bisexual man. Through their work together, Jane and Geraldo discussed strategies to foster other connections on campus as an openly bisexual man. In addition, Geraldo increased his visits back home to forge stronger relationships with his parents before coming out to them. In addition, he disclosed that he had come out to Dr. Porto, who expressed warmth and support to him. Through RCT, Geraldo was able to cultivate a more positive self-concept, engage in authentic and empowering relationships, and gain strategies and experiences to build new connections and dismantle previous disconnections.

Intersectional theory has extended beyond the experiences of Black women. Applied to counseling theory, counselors can explore how different combinations of privileged and oppressed statuses intersect to yield various individual and institutional connections and disconnections. An intersectional approach focuses on the pressures that impact persons of all genders (e.g., transgender, agender, and genderqueer), including those of cisgender men. Regardless of the gender of your client, it is important to work with them to unpack how their gender identity and other intersecting identities have affected their lived experiences, their mental health, and their perceptions about what they can and cannot do in their lives. In addition, they help clients to identify negative beliefs or relational images and then challenge clients' negative beliefs about self and others by exploring instances when their belief is unfounded (Flores & Sheely-Moore, 2020). Clients can then begin to reformulate internalized negative messages into more positive schemata that foster positive self-worth.

With respect to spiritual issues, there is increasing theoretical writings about the use of RCT to address spiritual and religious considerations, particularly for women and those of other marginalized statuses. For example, Avent Harris et al. (2021) proposed an integrative framework incorporating RCT and womanist theory in the following phases: (a) assessment; (b) building healthy relationships; and (c) therapeutic outcomes.

- **Assessment:** Assessment can include open-ended questions and prompts as well as creation of a genogram. Examples of questions and prompts are as follows: "Tell me about the important relationships in your life"; "How would you describe your relationship with religion/spirituality?"; "How do you describe your relationship with your faith community?"; "Give me an example of a relationship in your life that you feel is empowering and one that feels disempowering"; and "What does community look like for you?" Genograms that include spiritual and other relational components are co-developed between the counselor and client, whereas important relationships, including those such as those found in the Black church and other "nontraditional" relationships, are articulated.
- **Building healthy relationships:** Through centralizing the therapeutic relationship as a corrective model, new relationships within spiritual and religious realms are explored. Counselors affirm with clients that seeking relationships that foster gender, racial, spiritual, and other identities are, in fact, growth producing for positive mental health and wellness outcomes. As such, counselors reflect with clients about connections that support empowerment and liberation.
- **Therapeutic outcomes**: Aligned with RCT goals, interventions that support connection with religious and spiritual environments are examined. Avent Harris et al. (2021) proposed several therapeutic interventions: (a) identifying ways in which the religious ideology has fostered disconnection and upheld discrepant and marginalizing relational images; (b) proposing a healthy spirituality as a potential positive force; and (c) fostering spiritual community activism, or ongoing anti-oppressive thoughts and actions that are informed by a higher power.

Efficacy of RCT

Although research on the effectiveness of RCT is still developing, available scholarship demonstrates its efficacy with diverse populations for a range of clinical concerns. For example, Lenz (2016) conducted the most recent systematic review on RCT studies and noted that more than 40 articles have been published outlining its effectiveness. As RCT has expanded its application to counseling men, transgender individuals, people of color, and those of a myriad of intersectional privileged and oppressed statuses (e.g., Jordan, 2018; Flores & Sheely-Moore, 2020; Mereish & Poteat, 2015; Storlie et al., 2017), evidence of its utility to yield positive psychological and interpersonal outcomes is expected to also expand.

Constructs associated with RCT have also been supported through the creation and validation of various psychometric instruments (Lenz, 2016). These assessments include the Mutual Psychological Development Questionnaire (MPDQ; Genero et al., 1992), the Relational Health Indices (RHI; Liang et al., 2002a, 2002b, 2008, 2010), and the Connection–Disconnection Scale (CDS; Tantillo & Sanftner, 2010). These instruments examine the ability of a person to develop a healthy connection with others, a key RCT goal. Using these scales, and through other research, the following are examples of some outcomes of RCT:

- improved relationship functioning (Morray & Liang, 2005; Spencer et al., 2004);
- reduction of disordered eating symptoms (Tantillo & Sanftner, 2003);
- reduction of self-injurious behaviors (Haberstroh & Moyer, 2012; Trepal, 2010);
- increased relational empowerment and engagement for incarcerated adolescent females (Lenz et al., 2012);
- improved adjustment for individuals and their families living with cancer (Kayser et al., 2007; Raque-Bogdan, 2019);
- increased self-confidence and connections among at-risk mothers of infants (Paris & Dubas, 2005);
- improved clinical outcomes with LGBTQ+ clients (Chan et al., 2021); and
- improved therapist trainee learning and mentorship using RCT principles (Byers et al., 2020; Dipre & Luke, 2020; Ross-Shefiff et al., 2017).

Although there is a need for more research on the efficacy of RCT, with the development of instruments and the expanded application of RCT to a broad range of populations and issues, it is likely that more studies will be conducted in the future. As such, we suggest the following research directions:

- quantitative studies to include randomized control trials, systematic reviews, and meta-analyses of RCT constructs (e.g., relational images, disconnection, and mutual empathy);
- baseline and changes in measurement of symptomology during, after, and upon follow-up of RCT;
- qualitative studies examining the lived experiences of clients reporting disconnection, including the strategies they use to disconnect and reconnect;
- quantitative studies employing RCT-relevant tools (e.g., MPDQ, RHI, and CDS) to examine within- and between-session effects of RCT; and
- greater attention in quantitative, qualitative, and mixed methods studies to cultural demographics of participants.

The Millers

The following shows Ann going through RCT. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Ann and RCT

Solange sat in her office thinking about her next client, Ann, whom she had been seeing for about three months. Ann, who is in her mid-60s, had moved to town to be close to her son, Jake, and his children, Cecilia and Luke, but often found herself feeling isolated and not entirely connected to the family. Ann felt especially distant from Angela, Jake's wife, and the two often found themselves

in disagreements that appeared to be about one thing but were perhaps about something much deeper and, as yet, unnamed. At least the "something" between Ann and Angela had not yet found a name in therapy.

In her early sessions, Solange had worked to cultivate a relationship with Ann in which she could bring her own authenticity into their work together. Solange felt that only through an authentic relationship could Ann find the ground necessary to plant the seeds of mutual empathy, which would, in turn, provide what was needed for Ann to experience growth through connection with others and bring an end to her feelings of isolation. Solange hoped that in today's session she would gain a sense for Ann's relational image—the template that set the stage for her relationships with others, especially other women.

As their session began, Solange asked, "Ann, you've been talking a bit about these conflicts with your daughter-in-law, and I wondered if you would describe for me what conflict is like for you in general, not just with Angela but with other women and with men, too."

"I guess I've never known what to do with conflict of any kind. When I was a girl it was made pretty clear to me that being argumentative, or using a certain kind of language or just being critical, was not at all ladylike. My parents, and especially my grandmother, really impressed on me the importance of civility in relationships. The importance of being like Mary, kind, quiet, supportive and faithful, and not like a wailing banshee."

"So when you find yourself in a moment of tension with another person, like Angela, what happens inside you? Are you still trying to be like Mary?" Solange asked.

"No, no," Ann laughed, "Somewhere along the way I left behind the hope of being saint-like in the way I responded to others. Instead, I think I more or less leave the scene. My body is still there, but I retreat. I can feel my shoulders get tight, and I know I clench my jaw because my teeth sometimes hurt. But it keeps me from saying something I might regret or looking like a crazy person ready for the nut house."

"There is a self-protective moment of disconnect that you experience in those moments," Solange observed, "Instead of suffering through the conflict as Mary might, you retreat where your spirit can be safer, but you feel the pain in your body. And what happens after the conflict? You notice your shoulders and teeth aching, and what do you notice between you and Angela?"

"Well, then, there is silence and awkwardness. A lot of it. And if Jake is home that spreads to him because he doesn't like to see us fighting. It makes him anxious. So then I feel this distance between us. It is terrible," Ann stared off into a corner of the room almost as if she was watching this scene unfolding in front of her.

Solange allowed for some silence and then offered, "Ann, tell me if this sounds right to you. You were raised to be one kind of woman—a woman who avoids conflict, and though you have given up being saint-like, you have continued to avoid expressing your feelings fully and have instead chosen to retreat. The retreat helps you avoid feeling like a banshee, or as emotionally unstable, but you feel the consequences in your body and in a feeling of disconnection, not only from Angela but from Jake, too," Solange said, adding, "The pain is palpable in your body, but the disconnection is the more sustained and difficult hurt."

"Yes, that's true. It is so, so painful. So I try everything to avoid conflict. I just zip my lip and try to be as careful as possible so that there won't be a disagreement," Ann sighed. "But that feels stiff and awful, too. I feel like such a failure as a mother. I just make the house so uncomfortable, not warm and welcoming, as a mother should. I don't know what is wrong with me."

"Your voice is so full of discouragement. I wonder if it would help to know that you are not alone in this experience of feeling disconnected. I wonder, too, if it helps to know that a lot of people in our society and even mothers in families they love find themselves in relational dynamics that that have constructed obstacles to connection," Solange offered.

"Well, I'm sure that is true, but what do you mean exactly?" Ann asked.

"I think what I am saying is that, perhaps, this disconnection that you have experienced is not a problem that exists because of some failing within you, or even a problem in Angela, but a problem that was created by social expectations—in your case, the expectations around what it means to be the right kind of woman—a woman more like Mary and less full of feeling, hurt, and protest, like the banshee. My sense is that these early lessons from your family, your grandmother especially, and likely your community, gave you the materials to construct a relational image—a kind of template for how you would be with others. That relational image has not afforded you the freedom to bring your whole self into relationship with others, making it difficult to come into full contact with others and, thus, the heartbreaking and ongoing sense of disconnection. Does that resonate for you, Ann, or is that overstated?" Solange offered.

"I have thought of this before, but I haven't ever really connected the dots quite like that. I do get the sense that Jake and Angela don't really know me, and maybe my husband never really knew me either. It feels both deeply sad but also affirming to hear you frame my situation this way. I don't just feel disconnected as I'm leading up to a conflict and afterward—it's most of the time. Oh! I would love so much to have that connection, something real," Ann said, her eyes moistening.

"I wonder how that relational template plays out in here. I wonder if you feel that distance between us as well, a feeling of not being fully known," Solange asked, moving forward in her chair a bit, curious about what Ann might say.

Ann paused a moment, "I think in our first sessions I did feel that in myself. In the way I so carefully dressed for our session so that you wouldn't think I was nutty but also so that I might seem like someone you would take seriously. Like I had something to contribute. I think I was really careful with my words and maybe my posture, too, to kind of do image control. But now I feel more relaxed and maybe more real with you," Ann said.

"What helped you to make that shift, Ann?" Solange asked, still curious.

"Well, it's funny. You'd think it would be your empathy and the way you listen carefully. And that helps, don't get me wrong, but it was a moment of authenticity from you that shifted that for me. It was when we started our session and your cellphone rang. You looked so surprised and irritated and you said, 'Damn it.' I hadn't expected that, and somehow it delighted me and brought me closer to you. I could see your irritation and your embarrassment, and it made it easier to be honest about myself," Ann said, smiling.

"That is affirming to hear. I ask that question because I have felt a shift in the last two sessions, I have felt that you have brought more of yourself. I feel I know more of the Ann others don't see. It delights me to know this other part of you, in the same way that you were a bit delighted to know that I also feel impatient and embarrassed at times," Solange shared.

"I appreciate you saying that," Ann replied, "It feels important to know that you feel a shift, too. Can I run a thought by you? I'm still thinking about what you said about the way I was raised and the ways of being I've developed to be closer to others—what did you call that? A relational image? Well it is funny. I feel like the more I try to be what others want me to be, the more I feel like no one knows me. I feel almost hopeless about being known, and it just feels so ironic," Ann shared, looking pointedly at Solange.

"Oh, I think you are onto something there, Ann, something I would call a cultural-relational paradox. There is a demand that you enact a certain role in order to be socially accepted, and the more you try to fulfill that role, the more isolated and perhaps powerless you feel. You are left with a nagging sense of loss and heartache that you described earlier," Solange replied enthusiastically.

As Solange reflected on her session with Ann, she felt satisfied that, together, they were beginning to get an idea of Ann's relational image and forming a sense of how this image was playing out in her relationship with Angela and with others. Solange was disinclined to pathologize Ann's reluctance to confront conflict or to show her true self to others and, instead, felt that Ann's disconnection and desire for contact with others fueled Ann's hesitancy to be fully authentic. She hoped that in later

sessions Ann would be able to begin to cultivate a deeper sense of connection within the therapy setting, establishing a sense of mutuality and deep felt sense of experiencing empathy. Solange believed that through this process Ann would continue to grow and that through this growth she would see change in her relationships with her family and perhaps even her friends.

For You to Consider

1. What social pressures and oppressions might Ann have been exposed to as she grew up and in society currently?
2. Do you believe we live in a patriarchal society that has negatively impacted Ann's development and the development of women in general? If yes, how?
3. How might expectations around age create a cultural paradox for Ann? How might Solange explore the impact of ageism in Ann's life and her sense of herself?
4. Do you think Ann has had much opportunity to explore who her authentic self might be? How does RCT help a client explore their authentic self?
5. How long do you think it might take for Ann to more fully understand who she is to the point where social demands and oppressions are not playing a large role in shaping her interactions and feelings?
6. Do you think that RCT would be effective with Angela or Jake? What relational images have Angela and Jake developed?
7. How might Angela's and Jake's relational images impact the ways in which they relate to one another and the world?
8. What cultural expectations do you think impacted Angela, especially in light of her being biracial?
9. How comfortable would you be to bring up issues related to social pressures and oppressions into the therapy room? Which oppressions would be easy to talk about? Which would be less comfortable?
10. In considering your own life experiences, what oppressions have been present in your experience? Are there ways they have caused you to feel isolated from others or to experience a sense of loss?
11. Have you experienced a cultural relational paradox in your life? If yes, why? If not, why not?
12. How would you support a client in becoming connected without losing their own distinctive identity?

Summary

This chapter began with a biography of Jean Baker Miller. Born into a working-class family in the Bronx, Miller's experiences as a woman and her desire to advocate for all oppressed individuals were important vehicles in her developing RCT. After obtaining her degree in psychiatry, she obtained positions at Boston University and Harvard Medical School. Soon, she wrote the well-known book, *Toward a New Psychology of Women*, and eventually became director of the Stone Center for Developmental Services and Studies at Wellesley College. This was the place that allowed her, with other scholars, to fully develop her theory.

The feminist movement of the 1960s and 1970s served as a catalyst for the formation of RCT. Soon after, a number of feminist scholars, such as Sandra Bem, who developed the Bem Sex Role Inventory, and Carol Gilligan, who examined the moral development of girls and women, began to popularize the notion that the lived experience of women is often very different than that of men. With this in mind, a number of women began to develop the notion of feminist therapy, including Laura Brown, Bonnie Burstow, and Judith Worrell. However, it was Jean Baker Miller, along with Irene Stiver, Jan Surrey, and Judith Jordan, who developed RCT, one of the first feminist approaches to conducting counseling.

Regarding the view of human nature of RCT, we noted that, as a postmodern approach grounded in social constructionism and humanism, this approach asserts that individuals construct their identities and understanding of the world through their unique experiences. Although viewing the individual through a phenomenological lens, it also appreciates the importance of relationships and community in the growth of the individual. Thus, it is also known as a collectivist approach. RCT is also developmental, as it states that growth can be ongoing and is specifically related to significant relationships that are best nurtured through mutual respect and empathy. As such, it is antideterministic, as growth can occur at any point in one's life. Finally, an important tenet of this approach is its commitment to feminist values, which includes understanding how gender, race, ethnicity, sexual identity, social class, ability status, and other factors impact individuals' lived experiences, and their mental health. Key concepts of RCT were noted by highlighting the following eight principles: (a) people grow through and toward relationships throughout the lifespan; (b) movement toward mutuality, rather than movement toward separation, characterizes mature functioning; (c) relational differentiation and elaboration characterize growth; (d) mutual empathy and mutual empowerment are at the core of growth-fostering relationships; (e) authenticity is necessary for real engagement and full participation in growth-fostering relationships; (f) in growth-fostering relationships, all people contribute and grow or benefit—development is not a way one-way street; (g) development of increased relational competence and capacities over the lifespan is a goal; and (h) mutual empathy is the primary means from which we grow.

Some of the most important techniques that were highlighted in this chapter included respecting the client, showing curiosity and wonder, being nonpathologizing, and demystifying the counseling relationship; demonstrating acceptance, authenticity, and empathy; analyzing counselor–client power differentials; encouraging discussion about oppression and marginalization; encouraging empowerment, high self-esteem, assertiveness, and emotional identification and expression; and asking questions about the client's life.

When discussing the therapeutic process, we first noted it was driven by eight guidelines, which include: (a) recognizing the harmful effects of a patriarchal culture; (b) exploring inherent contradictions in prescribed gender roles; (c) supporting clients in the exploration of their inner resources; (d) integrating other therapeutic modalities into the RCT approach; (e) demystifying the power relationship inherent in any therapeutic relationship; (f) matching women clients with women therapists; (g) conducting ongoing evaluations of practice; and (h) knowing that therapy is not a cure-all.

Given the guidelines, RCT can be viewed as a series of phases that parallel the techniques noted earlier. First, clients often enter counseling unaware of the sociocultural pressures that have impacted them. However, by not pathologizing clients, and through respect, empathy, acceptance, demystifying the relationship and downplaying power differentials, clients slowly open up and begin to realize how they have been marginalized by gender and other cultural identities. In addition, the counselor defines the relationship as a mutual journey, where both the counselor and client can grow and learn from one another. Soon, clients realize that their lack of power and privilege has led to feelings of oppression, a sense of marginalization, and disconnection. Here the use of questions may be used to help clients explore how their family, culture, and society have impacted

their sense of self. After the realization that clients have lived inauthentically in prescribed societal roles, they are ready for the next phase of therapy—the development of a new identity. Counseling nears its conclusion when clients have developed a new sense of self, feel more as an equal with the therapist, have likely developed new friendships that reinforce their new sense of self, and are willing and able to engage in ongoing constructive and healthy discussions with others with whom they are in relationships.

Relative to social, cultural, and spiritual issues it was highlighted that RCT can be an invaluable approach to working with women as well as individuals who have been marginalized in society and negatively impacted by power and oppression. The importance of recognizing one's intersectionality in practice was also highlighted, and CRT and intersectional theory are two well-aligned frameworks with RCT. Thus, unpacking clients' experiences of gender, race/ethnicity, sexual identity, social class, ability status, religion, spirituality, socioeconomic status, age, and other unique identity factors are, today, an important focus of RCT.

Although a relatively new approach to therapy, a limited number of studies with varying groups have found it to be effective. However, RCT is increasingly being applied to counseling men, transgender individuals, people of color, and those of intersecting cultural identities. With its expanded use, it is likely that RCT efficacy research will increase substantially in the near future. In addition, instruments that measure the ability of a person to develop a healthy connection with others, a key component of this approach, have been developed and used in research. Although more research needs to be conducted, clearly, RCT has begun to make the vital steps toward showing its efficacy.

Key Words and Terms

analyzing counselor–client power differentials
androgynous
antideterministic
asking questions about the client's life
Bem Sex Role Invenotry (BSRI)
binary gender roles
collectivist approach
connection
constructionist approach
critical race theory
cultural–relational paradox
demonstrating acceptance, authenticity, and empathy
developmental approach
difference feminism
disconnection
eight guidelines of the therapeutic process
eight principles of key concepts
encouraging discussion about oppression and marginalization
encouraging empowerment, high self-esteem, assertiveness, and emotional identification and expression
feminist approach
feminist values
five good things
- empowerment to act
- clarity/knowledge of self and others
- desire for more connection
- increased sense of zest
- self-worth

humanistic approach
intersectional theory
intersectionality
isolation
mutual empathy
natural disposition toward relationship and connection
oppression
phenomenological
postmodern approach
power
privilege
relational approach
relational images
relational self
respecting the client, showing curiosity and wonder, being nonpathologizing, and demystifying the counseling relationship
self-in-relation model
social construct
social constructionist
standard of care
strategies of disconnection

Key Names

Abzug, Bella
Bateson, Gregory
Bell, Derek
Bem, Sandra Lipsitz
Bernays, Anne
Brown, Laura
Burstow, Bonnie
Crenshaw, Kimberlé
Erikson, Erik
Friedan, Betty
Freud, Sigmund
Fromm, Erick
Gilligan, Carol
Jordan, Judith
Kohlberg, Lawrence
Lynd, Helen Merrell
Mead, Margaret
Miller, Jean Baker
Miller, Jon
Miller, Ned
Miller, S. "Mike"
Steinem, Gloria
Stiver, Irene
Sullivan, Harry Stack
Surrey, Jan
Worrell, Judith

CREDITS

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SECTION V

EMERGING AND CONTEMPORARY THEORIES

Whereas each of the prior four sections of the text represent theories that share similar theoretical underpinnings, this last section presents three theories that have arisen in recent years due to their popularity and, to some degree, the efficacy of their approaches. The first approach, dialectical behavior therapy (DBT), is a third-wave cognitive-behavioral approach that views personality formation as a complex interaction between behavior, biology, and context (environment). The approach, originally developed for individuals diagnosed with borderline personality disorder (BPD), has become a treatment of choice for BPD and related disorders. It uses a wide variety of techniques to help clients modulate emotional dysregulation. The second theory, acceptance and commitment therapy (ACT), is also a third-wave cognitive-behavioral approach that encourages clients to accept who they are while helping a person learn and practice psychological flexibility as they move toward new ways of being in the world while changing the context of their experiences. The last approach in this section provides an overview of neurocounseling, one of the most cutting-edge theories today. Neurocounseling is a wellness and strength-based approach that integrates neuroeducation and neuro enhancing activities into the counseling process in an effort to positively impact the structural biology of the brain. Although the chapter looks at many ways of producing such changes, it also briefly introduces two neuroinformed therapies: prolonged exposure (PE) therapy and eye desensitization movement reprocessing (EMDR).

Although no video files accompany these chapters, you and your instructor are encouraged to find readily available YouTube videos that demonstrate the techniques of these theories.

14 Dialectical Behavior Therapy[1]

Learning Goals

At the conclusion of this chapter, readers will:

- be familiar with Marsha Linehan and the development of dialectical behavior therapy (DBT)
- understand the view of human nature of DBT, including its behavioral and existential–humanistic leanings
- be able to articulate key concepts related to DBT, including borderline personality disorder, emotional dysregulation and emotional regulation, biosocial theory, dialectical philosophy, behaviorism, Zen Buddhism and mindfulness, and the seven basic assumptions when treating clients using DBT
- understand the pretreatment skills of DBT, including assessment, psychoeducation, explanation of the purpose, and a verbal or written agreement
- be able to describe the skills found in stages I–IV of individual therapy, including structuring therapy, the diary card, chain analysis, dialectical communication skills, behavioral skills, cognitive skills, and reinforcement of group skills
- understand group skills training, specifically the acceptance skills (mindfulness and distress tolerance) and change skills (emotional regulation and interpersonal effectiveness)
- be able to give a brief explanation of the purpose of consultation team meetings in DBT
- be able to articulate of the purpose of phone coaching in DBT
- understand the counseling process of DBT
- have knowledge of the social, cultural, and spiritual applicability of DBT
- be familiar with research on the efficacy of DBT

This initial chapter of Section V provides a biography of Marsha Linehan, considered to be the founder of dialectical behavior therapy (DBT). We then describe the view of human nature from a DBT perspective, followed by its key concepts; DBT techniques and therapeutic process; social, cultural, and spiritual issues associated with DBT; and DBT efficacy research. We conclude the chapter by illustrating this approach with Jake, a member of the Miller family.

1. The authors are grateful to Francisca Rivas, Ne'Shaun Borden, Johana Rocha, and Kyulee Park for their contributions to a previous version of this chapter in the text, *Contemporary Theories in Counseling & Psychotherapy* (Neukrug, 2021).

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Marsha Linehan

> The bottom line is that if you are in hell, the only way out is to go through a period of sustained misery. Misery is, of course, much better than hell, but it is painful nonetheless. By refusing to accept the misery that it takes to climb out of hell, you end up falling back into hell repeatedly, only to have to start over and over again. (Linehan, 2015a, p. 461)

FIGURE 14.1 Marsha Linehan

This quote by *Marsha Linehan*, the founder of *dialectical behavior therapy* (DBT), says it all. Those who struggle with mental illness are in hell, and it takes a lot of effort to get better. And according to Linehan, it is going to be slow and hard work as they climb up through purgatory and very slowly move toward a bit of joy in their lives. But who is Marsha Linehan?

Born May 5, 1943, in Tulsa, Oklahoma, Linehan was the third child of six: a bright student who felt unloved and inadequate compared with her siblings. At 17, while exhibiting symptoms of self-loathing, self-destructiveness, and social withdrawal, a psychiatrist recommended inpatient treatment and diagnosed her with schizophrenia.

Remembered by staff members and fellow patients as frequently attacking herself, burning her wrists with cigarettes, cutting her arms, and banging her head against the wall and floor, at the hospital she was medicated with Thorazine, Librium, and other psychotropic medications and even given electroshock treatments. In a *New York Times* article, Linehan reminisces on those times:

> My whole experience of these episodes was that someone else was doing it; it was like 'I know this is coming, I'm out of control, somebody help me; where are you, God?' ... I felt totally empty, like the Tin Man; I had no way to communicate what was going on, no way to understand it. (Carey, 2011, para. 14)

Later in her life, Linehan would argue that she had been misdiagnosed, treated inappropriately, and believes she had the characteristics of borderline personality disorder, not schizophrenia.

After 26 months of psychiatric treatment, Linehan was released from the hospital. Her discharge summary noted she was one of the most disturbed patients in the history of the hospital, and her doctors doubted her ability to successfully live outside of the hospital. Vowing to "come back and get others out of here" (Carey, 2011, para. 23), Linehan returned home, but after struggling with suicidal ideation, she moved to Chicago in her mid-20s in hopes of starting a new life. Despite having stable employment, she felt lost, confused, and lonely in Chicago. Finding some solace in her Catholic faith, one night while praying she had a transformative realization:

> One night I was kneeling in there, looking up at the cross, and the whole place became gold—and suddenly I felt something coming toward me. It was this shimmering experience, and I just ran back to my room and said, 'I love myself.' It was the first time I remember talking to myself in the first person. I felt transformed. (Carey, 2011, para. 27)

This awareness eventually led Linehan to adopt the paradoxical practice of *radical acceptance* and *commitment to change* that was to become a foundational aspect of DBT (Linehan, 2020). After

earning her bachelor's in psychology, and then her master's and doctoral degrees in social and experimental psychology, from Loyola University in Chicago, Linehan pursued a postdoctoral clinical internship at the Suicide Prevention and Crisis Service in Buffalo, New York and a postdoctoral behavioral therapy program at the State University of New York, Stony Brook. Passionate about working with individuals with suicidal ideation and writing about her ideas for change, over the years she held a number of clinical and faculty positions. Linehan retired in 2019 as professor of psychology and adjunct professor in psychiatry and behavioral sciences at the University of Washington.

From early on, Linehan's research interests included suicidality, parasuicidality, personality disorders, behavior modification, and cognitive-behavioral treatment. These interest areas, along with her curiosity in radical acceptance and her work and research with suicidal individuals with borderline personality disorder, resulted in DBT and the writing of several well-received articles on DBT (see Linehan, 1987a, 1987b, 1989, 2020).

While finalizing DBT, Linehan decided to take time off from work to immerse herself in learning radical acceptance. Spending two months at a Buddhist monastery practicing radical acceptance and letting go of desires, under the guidance of a Zen master, her spiritual journey led her to incorporate *mindfulness* as one of the key components of DBT (Linehan, 2017a, 2020). She continued her spiritual training under *Gerald May*, an American psychiatrist, who was half-brother of *Rollo May*; *Tilden Edwards*, an Episcopal priest and founder of Shalem Institute for Spiritual Formation; and *Willigis Jager*, a German Benedictine monk. Linehan herself is a Zen master (Roshi) in the Sanbo-Kyodan School and the Diamond Sangha.

Fearful that speaking openly about her mental illness would undermine her theory and her credibility, for years Linehan was hesitant to talk about her struggles. Then, after one of Linehan's patients said, "... if you were [like us], it would give all of us so much hope" (Carey, 2011, para. 2). It was at this time that Linehan decided to share her story and gave a public talk, entitled "Succeeding by Failing, the Personal Story Behind DBT."

Linehan continues to be an active researcher, educator, and advocate of DBT and has authored more than 100 journal articles, several books, and manuals that have been translated into multiple languages. For her outstanding work, she has received dozens of awards. Some of her more noteworthy awards include: the Louis I. Dublin Award for Lifetime Achievement in the Field of Suicide (1999), Distinguished Scientist Award from the American Psychological Association (APA, 2001), Career Achievement Award from APA (2005), Gold Medal for Lifetime Achievement in the Application of Psychology Award from the American Psychological Foundation (2012), Scientific Research Award from the National Alliance on Mental Illness (2015), Career/Lifetime Achievement Award from the Association of Behavioral and Cognitive Therapies (2016), and the $100,000 Grawemeyer Award in Psychology (2017; Linehan, 2017b).

View of Human Nature

DBT's understanding of the person is largely based on the *biosocial model of personality formation*, credited mostly to *Theodore Millon*. Millon (1969) suggested that children are born with specific *constitutional factors* related to their physical ability, intellect, drive, energy, and temperament. A child's emotional world can be impacted by how these factors are shaped through childhood experiences, such as parenting, peer relationships, and other environmental factors. Childhood experiences that create a *negative* or *invalidating environment* can impact constitutional factors in a manner that lends the child and developing adult toward *emotional volatility* and *dysregulation* and associated behaviors, and it puts them at risk of developing BPD or related mental disorders (Kuo & Fitzpatrick, 2015; Linehan, 2015a).

To treat BPD and related mental disorders, DBT relies on cognitive and behavioral theory, while also integrating Eastern philosophy and existential–humanistic concepts (Hayes & Hofmann, 2017; Pederson 2015). Considered a type of *third wave of cognitive-behavioral therapy* (CBT), DBT and other third-wave approaches view personality formation as a complex interaction between behavior, biology, and context (environment) and focus on a wide range of techniques to assist clients in accepting and changing their ways of being in the world.

Although DBT relies on several behavioral techniques, it does not solely focus on changing specific behaviors, as did *first-wave cognitive-behavioral therapy* (e.g., operant conditioning, classical conditioning, and modeling). Also, in contrast with traditional cognitive therapy that tends to zoom in on cognitive distortions and irrational thinking by replacing faulty thinking (*second-wave cognitive-behavioral therapy*), DBT focuses on adopting an increasingly flexible and relativistic view of the world, so the person is not embedded in rigid ways of thinking, which tend to exasperate problems. Instead, DBT and related third-wave approaches tend to emphasize "mindfulness, emotions, acceptance, relationships, values, goals, and meta-cognition" (Hayes & Hofmann, 2017, p. 245), along with a number of traditional behavioral techniques and modified cognitive techniques when working with clients.

Recognizing that change is slow and difficult but possible for most clients; DBT suggests the importance of radically accepting clients and encouraging them to accept themselves (Linehan, 2017a, 2020). With this theme in mind, building the therapeutic alliance by listening, being empathy, and showing radical acceptance is critical and borrows from many of humanistic skills found in person-centered counseling. Also, other techniques borrowed from existential therapy and gestalt therapy are used to encourage clients to examine what is important in their lives and to help them see the polarities within themselves. Understanding the *dialectics* (polarities) of life, particularly of *acceptance and change*, is critical to the work of the DBT counselor. In fact, embracing dialectics is so critical that it is viewed as a practice all DBT counselors should actively embrace in their lives. One popular method used to help foster dialectical thinking is the practice of *mindfulness*, a technique related to the Eastern philosophy of Zen Buddhism. Important for counselors and clients alike in their journey toward self-acceptance, this practice is often viewed as the first step toward change. DBT is an approach grounded in many cognitive-behavioral traditions but clearly integrates existential–humanistic skills, mindfulness, Eastern philosophy, and more, as it fosters deeper meaningfulness in clients' lives. It promotes the practice of radical acceptance, the belief that people can change, and a wide range of philosophies and techniques to promote such change.

Key Concepts

Because DBT was developed to treat individuals with *borderline personality disorder (BPD)*, this section starts with a short description of BPD. We then go on to describe some important aspects related to the theoretical underpinnings of DBT, including *biosocial theory*, *emotional dysregulation* and *emotional regulation*, *dialectical philosophy*, *behaviorism*, and *Zen Buddhism* and *mindfulness*. We conclude with the *seven basic assumptions of DBT*.

Borderline Personality Disorder

Through Linehan's early work with suicidal and parasuicidal clients, she realized that many of her clients met some, or all, of the diagnostic criteria for BPD (Linehan, 1993a). Although she knew little about BPD at the time, Linehan (2017a, 2020) quickly came up to speed on the emotional, interpersonal, behavioral, and cognitive dysregulation characteristic of BPD. Clients diagnosed with BPD often have a difficult time functioning in relationships, engage in nonsuicidal self-injurious behavior, and are at much higher risk of suicidal behaviors. Also, they tend to have a particularly

difficult time in counseling, often leaving their practitioners feeling helpless as they struggle to make progress, usually with little success. Kuo and Fitzpatrick (2015) summarize the symptoms needed in *DSM*-5 for a diagnosis of BPD:

1. frantic efforts to avoid imagined abandonment,
2. instability in interpersonal relationships,
3. identity disturbance,
4. impulsivity,
5. suicidal behaviors,
6. emotional instability,
7. chronic feelings of emptiness,
8. inappropriate or intense anger, and
9. stress-related paranoid ideation or dissociation. (p. 294)

Although less than 2% of Americans are thought to be diagnosed with BPD, up to 20% of the inpatient psychiatric population are thought to have BPD, and 42.4% of those diagnosed with BPD seek treatment for the disorder (Chapman et al., 2021; Lenzenweger et al., 2007; National Institute of Mental Health, n.d.). In addition, ten Have et al. (2016) found that approximately 25% of people have one or two symptoms of BPD, and another nearly 4% have three or four symptoms of BPD. Thus, individuals with BPD or related disorders, as well as individuals who have some of the symptoms of BPD, make up a substantial percentage of those who seek counseling.

With high numbers of individuals with BPD or related symptoms or disorders seeking counseling, Linehan quickly realized the treatment options were not adequate and often resulted in poor outcomes and high dropout rates, and they were particularly stressful for practitioners (Linehan, 1993a). She eventually concluded that traditional cognitive-behavioral therapies that were often used to treat individuals with BPD focused too much on change and not enough on reducing the ongoing dysregulation, common in clients with BPD. To improve the quality of life for these individuals, Linehan recommended that clinicians go beyond treating the symptoms and recognize, and respond to, the complex cycle of emotional dysregulation some clients endure. Instead of focusing on symptoms, she used a biosocial lens to understand the complexity of their situations and work with them accordingly.

Biosocial Theory

As noted earlier, the biosocial model of personality formation, credited mostly to *Millon,* suggested that children are born with constitutional factors, such as physical ability, intellectual capacity, drive, energy, and temperament, that shape their view of the world but can be expressed differently as a function of childhood experiences, such as parenting, peer relationships, and other environmental factors. This results in some children being hardwired for emotional vulnerability, and when that child is brought up in a negative or invalidating environment, they are increasingly at risk of developing BPD or other mental disorders (Kuo & Fitzpatrick, 2015; Linehan, 2015a, 2020).

Linehan (1993a, 2020; Rizvi et al., 2013) suggested that an *invalidating environment* from important caregivers (e.g., parents) can result in heightened emotional responses in some children, difficulty in regulating one's emotional responses, and a slow rate of returning to normality—symptoms typical of individuals with BPD or related disorders. For instance, a caregiver's continued ignoring or discounting of the child's emotional experiences can result in a child exhibiting extreme emotions

that are more likely to be attended to. Often, such children subsequently learn to associate those intense emotional expressions with attention.

As these children grow into adulthood, they have an inability to effectively communicate or problem-solve when situations become difficult, as they quickly resort to a heightened emotional state in their interactions with others (Crowell et al., 2009; Rizvi et al., 2013). It also makes it difficult for them to de-escalate their emotions. This constant cycle of emotional volatility makes individuals with BPD, or related mental disorders, have a difficult time understanding polarities in life and that two opposing thoughts can be simultaneously true (e.g., "I'm upset at my partner—I want a divorce," and "My partner brings me a sense of being grounded in life"). Thus, learning how to incorporate a dialectical philosophy is critical for individuals who have symptoms of BPD or related disorders and a good philosophy for all individuals to embrace.

Emotional Dysregulation and Emotional Regulation

Individuals with BPD, and related disorders, struggle with *emotional dysregulation*, which is the difficulty—or, even, inability—to moderate one's emotional experiences (Linehan, 2015a, 2020). Such individuals (a) are run by their emotions, (b) have difficulty processing information and cues from others, (c) demonstrate impulsive behaviors, (d) have difficulty making decisions, and (e) have behaviors that are dictated by cognitive distortions (e.g., all-or-nothing thinking, catastrophizing, overgeneralizing, personalizing, excessive use of "should and must" statements, and more). Pederson (2015) calls such cognitive distortions "stuck thoughts" to minimize stigma associated with the term. In addition, some individuals who cannot regulate their emotions express this problem through overregulation in which they (a) are out of touch and suppress their feelings, (b) experience and show little positive affect, and (c) cannot communicate their feelings effectively with others.

In contrast, *emotional regulation* is marked by an individual's ability to (a) moderate strong emotions, so their emotions do not dictate thoughts and behaviors, (b) effectively communicate one's feelings to others, (c) respond to strong emotions in ways that will positively de-escalate a situation, and (d) self-soothe, so strong emotions do not direct one's thinking and acting. Although emotional dysregulation is a hallmark of individuals with BPD, aspects of it are common to many disorders. Therefore, although DBT was originally used solely for individuals with BPD, it has been expanded and used with a wider class of individuals seeking counseling.

Dialectical Philosophy

Dialectical philosophy suggests that "reality is interrelated and connected, made of opposing forces, and always changing" (Rizvi et al., 2013, p. 74). In contrast with other forms of cognitive-behavioral treatments that focus on changing symptoms, Linehan suggested a dialectical framework should be the foundational philosophy that grounds the change process (Linehan, 1993a, 1993b). Such a philosophy suggests that reality is grounded in polarities that are always in tension—within the client, within the counselor, and between the client and counselor. For instance, the following show the inability of accepting the polarities of life:

- A client may see themself as evil and not recognize any goodness within.
- A counselor may believe a client has BPD and, thus, cannot change.
- A counselor may demand the client to be hospitalized, yet the client is adamant that they are well enough to not be hospitalized.

This yin and yang of life suggests that individuals need to increasingly understand opposing forces and simultaneously hold both in consciousness and, ultimately, learn how to integrate

opposing forces. For instance, in the first example just given, the client has to also recognize and accept the good in themselves. In the second example, the counselor needs to reconcile the fact that some change is possible for all clients, and in the last example the counselor and client need to come to a collaborative, satisfactory conclusion that takes into account the counselor's and client's differing views on hospitalization.

Acceptance vs. Change: The Overarching Dialectic of DBT

One *dialectic* that is core to the change process in DBT is acceptance vs. change. For example, depressed clients need to allow themselves to experience their sadness but also recognize their desire to experience contentment; clients who experience themselves as failures need to envision their successes; and clients who want to use substances need to also see their desire to be clean (Rizvi et al., 2013). Helping clients accept their current state of being, while also helping them recognize the possibilities of change, is the hallmark of the work of the counselor who practices DBT.

Three Common Dialectical Dilemmas of Individuals With BPD

At the core of working with individuals with BPD, or related diagnoses, is understanding three biosocial dialectical dilemmas that clients tend to face as a result of emotional dysregulation: *active passivity* vs. *apparent competence*, *emotional vulnerability* vs. *self-invalidation*, and *unrelenting crisis* vs. *inhibited grieving* (Koemer, 2012). Linehan (1993a, 1993b) suggests these polarities tend to be more biologically based (i.e., active passivity, emotional vulnerability, and unrelenting crisis), in which the person is underregulated or emotionally out of control, or socially based (i.e., apparent competence, self-invalidation, and inhibited grieving), in which the person is overregulated or attempts to overcontrol one's emotions. Neither are good. Individuals with BPD, or related disorders, tend to bounce back and forth between these states of being and have difficulty integrating these two opposite poles (see Figure 14.2).

- **active passivity vs. apparent competence:** Like learned helplessness, active passivity is when a person allows, and even encourages, others to determine their fate rather than taking any action oneself. With an emphasis on the word "apparent," apparent competence is the feigning of ability to the point that other people do not know, and cannot read, stressful situations a person may be going through.
- **emotional vulnerability vs. self-invalidation:** Whereas emotional vulnerability occurs when clients have strong emotional reactions to small situations that lead to excessive worry, overly strong reactions to others, and chaotic interpersonal relationships, self-invalidation is the discounting of one's emotional experience ("I shouldn't feel this way," "I should not be happy," or "I should never worry"). Invalidation can sometimes lead to self-injury. Both emotional vulnerability and self-invalidation result in an inability to deal effectively with one's emotions and difficulty in interacting with others in genuine and productive ways.
- **unrelenting crisis vs. inhibited grieving:** Individuals experiencing unrelenting crisis are in a constant high state of emotional calamity and catastrophe with which they feel some sense of familiarity, even though it tends to be destructive to relationships. In contrast, these individuals will sometimes move into an inhibited grieving state in which they avoid or negate their emotions. In either case, constant crises or inability to experience emotions are nongenuine and emotionally draining ways of living in the world, and individuals with BPD have not learned how to integrate manage these polarities appropriately.

Healthy individuals achieve balance between active passivity and apparent competence, emotional vulnerability and self-invalidation, and unrelenting crisis and inhibited grieving. For instance,

they will tend to take responsibility for their lives and do not have a strong need to demonstrate competence to others. They do not overly react to situations or discount their feelings, and they are not in seemingly endless crisis or trying to avoid their emotions. As a result of their biology and social rearing, healthy individuals have found a balance between these polarities that allows them to live relatively genuine lives with access to their feelings and the ability to respond to them in measured and reasonable ways.

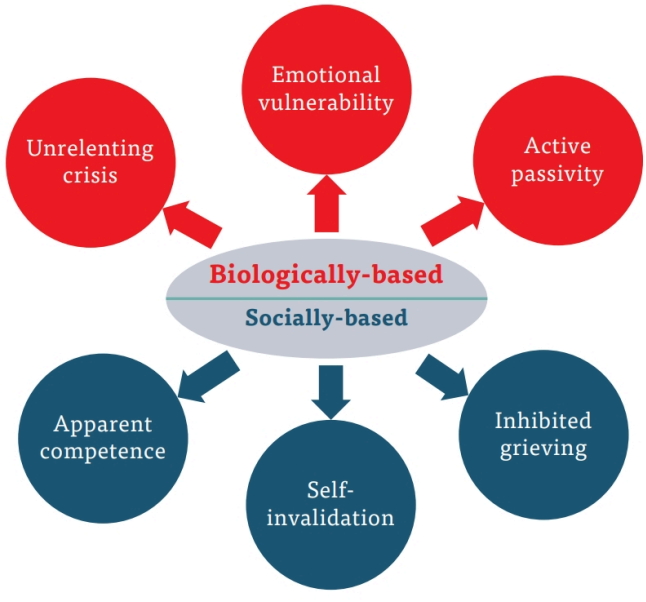

FIGURE 14.2 Three Common Dialectical Dilemmas

Behaviorism

When Linehan originally began her work with suicidal and parasuicidal clients, she used standard behavior therapy techniques (Linehan, 2020; Linehan & Wilks, 2015). Such an approach had its origins with traditional behavioral principles, such as classical conditioning, operant conditioning, and modeling paradigms, sometimes called the *first wave of CBT*. The advent of the cognitive approaches to therapy, such as *Albert Ellis's* rational–emotive behavior therapy and *Aaron Beck's* cognitive-behavioral therapy, added a focus on how thoughts impact problematic behaviors. Known as the *second wave of CBT*, these approaches added an important component to behavior therapy—the internal world of the client. Both first- and second-wave cognitive-behaviorism, however, focused on problem-solving strategies, and Linehan soon realized this constant focus on changing the problem was frustrating to most clients, with many of them lashing out at their counselors or dropping out of treatment.

Linehan (2016; Linehan & Wilks, 2015) soon recognized that if change were to occur at all, counselors needed to realize the importance of the therapeutic relationship in the change process, be radically accepting of their clients, teach their clients how to accept themselves, help clients understand dialectics, and use a variety of behavioral, cognitive, and other skills to help clients change. Within this context, counselors needed to accept that progress would be slow, that clients would have periodic setbacks and periodic gains, and, when working with highly volatile clients, needed to constantly be cognizant of their risk for suicide and self-harm.

Today, most DBT counselors will complete a *functional behavior analysis* of the client's situation, which examines how behaviors are linked to a person's problems. With such an understanding and with the assistance of their counselor and group skills trainer, clients can learn how to accept themselves and consider change. In the change process, DBT counselors will apply first-wave cognitive-behavioral techniques (e.g., operant conditioning, classical conditioning, and modeling), help clients examine rigid beliefs (e.g., "I am right, and you are wrong") and suggest more flexible ways of thinking, and use a wide range of other techniques to help clients integrate dialectical opposites and become less reactive to the world.

Zen Buddhism and Mindfulness

Linehan's positive experiences with deep prayer and meditation led her to learn about *Zen Buddhism* principles (Swales & Heard, 2017). Zen Buddhist philosophy underscores a number of principles that have been applied to DBT, including the importance of interrelatedness and

wholeness, continuous change, and recognizing the polarities of life (Robins, 2002). For instance, DBT asserts that counselors must help clients see that all things are connected (interrelated) and that addressing, or ignoring, problems will impact all aspects of one's life (the "whole") in complex ways. The idea that change is continuous throughout life suggests that counselors are to teach clients to accept themselves wherever one is in the moment and learn skills to help clients manage their emotions as changes occur. The final principle, recognizing the polarities of life, proposes that opposites exist contemporaneously, which suggests that clients should relinquish their dualistic view of the world (e.g., "I am always a bad parent") and adopt a complex way of thinking that embraces both sides of a polarity ("I am sometimes not a great parent and sometimes a pretty good parent").

Linehan (2015b) used these Zen principles to help conceptualize assumptions about clients, develop interventions, and identify treatment targets. In addition, believing that the practice of *mindfulness* embraces many of these Zen concepts, Linehan incorporated mindfulness into DBT by having clients learn it in group skills training and practice it in individual therapy, during their group sessions, and on their own. It is hoped such practice would help clients be increasingly tuned into the impact their actions have on self and others, be more accepting of themselves, understand that change is part of life, and think in more complex ways.

Seven Basic Assumptions of DBT

Underscoring the dialectic of acceptance and change and the importance of changing behaviors in all contexts of one's life are the *seven basic assumptions of DBT* (see Box 14.1).

BOX 14.1 Seven Basic Assumptions When Treating Clients Using DBT

1. **People are doing the best they can.** It is assumed that, at any point in time, people are doing the best they can.
2. **People want to improve.** Any person who is suffering wants to get better. People need to do better, try harder, and be more motivated to change.
3. **Although people are doing the best they can, if they are suffering, they need to try harder and be even more motivated to change.** This dialectic (doing the best one can and needing to try harder) is an important assumption for clients to learn.
4. **People may not have caused all of their own problems, but they have to solve them anyway.** Individuals are ultimately responsible for finding their solutions to their problems, though others (e.g., therapists) can be helpful along the way.
5. **New behavior has to be learned in all relevant contexts.** Any new behaviors that are learned must be generalized to all situations in which they are needed, not just applied to the situation in which they were originally learned.
6. **All behaviors (actions, thoughts, emotions) are caused.** There is a cause, or reason, for dysfunctional and toxic behaviors, even if the individual is not aware of the cause.
7. **Figuring out and changing the causes of behavior is a more effective way to change than judging and blaming.** One should not judge or blame oneself or others. Instead, one should work on finding the causes of behaviors and change them (Linehan, 2015a, p. 53; note that headings are direct quotes).

Therapeutic Techniques

DBT's therapeutic process is unique compared with traditional psychotherapies and consists of a pretreatment phase of counseling, followed by four modes that occur concurrently: *individual counseling, group skills training, consultation team meetings,* and *between-session phone coaching* (see Table 14.1). Treatment typically lasts four to five hours per week for six months to a year and employs a variety of techniques within each of the modes (Linehan, 1993a; 1993b; 2015a; Moonshine & Schaefer, 2019; Peterson, 2015; Van Dijk, 2012).

TABLE 14.1. The Modes of DBT Treatment

Mode	Time Frame	Major Goals	Professionals Involved
Pretreatment	1–3 sessions	• Explain purpose and process. • Orient client to therapy and obtain commitment. • Assess client and obtain diagnosis. • Complete psychoeducation: diagnosis, biosocial model, emotional dysregulation, dialectics, and more • Explain boundaries. • Obtain verbal and written agreement.	• Usually, the counselor who is providing individual therapy
Individual Counseling	1 hour per week	• Decrease suicidal and life-threatening behaviors. • Decrease therapy-interfering behaviors. • Increase quality of life behavioral skills. • Reinforce skills learned in group.	• The counselor providing individual therapy
Group Skills Training	2–2.5 hours per week	• Reduce behaviors very likely to interfere with therapy. • Skills acquisition and skill reinforcement	• Group skills trainer
Consultation Team Meeting	1–1.5 hours per week	• Keep counselor and skills group trainer motivated. • Consult about treatment and ensure its effectiveness. • Prevent counselor and skills group leader burnout. • Maintain DBT principles in practice via support and accountability.	• An individual counselor, group skills trainer, psychiatrist, and others
Between-Session Coaching	As needed	• Decrease suicidal and life-threatening behaviors. • Increase the generalization of behavioral skills. • Decrease sense of conflict, alienation, and distance from counselor and others.	• An individual counselor

The following offers an overview of the skills, techniques, and foci of the pretreatment stage of counseling, individual counseling, group skills training, consultation team meeting, and between-session coaching. Keep in mind, however, that DBT requires intensive training, and what is offered here is a smattering of some of the more common skills used. If you are interested in more involved training, you can obtain certification as a DBT therapist, which involves having a graduate degree in a mental health field, taking didactic training, obtaining clinical experience, taking an exam, and more (see www.dbt-lbc.org).

Pretreatment Stage

Usually led by the counselor who will be conducting individual therapy, the pretreatment stage involves *orientation and commitment* to the therapeutic process (Linehan, 1993a; 2015a; Moonshine & Schaefer, 2019; Pederson, 2015). Usually, a thorough *assessment* of the client's current living situation is conducted, an assessment for suicidality is completed, and a diagnosis is formulated. Then, psychoeducation about the diagnosis, the biosocial model, emotional dysregulation, and dialectics is provided. An explanation of the *purpose and process* of individual counseling, group skills training, and between-session coaching is given, and the *boundaries of the relationship* are noted. This helps alleviate any misconceptions about the process that clients may have. Ultimately, if counseling is to progress, the client must agree to attend all individual sessions and group skills training sessions and address suicidal, parasuicidal, and therapy-interfering behaviors as they arise. After the client agrees to the process, a *verbal or written agreement* is obtained, usually based on a six-month to one-year therapeutic renewable plan. This helps to reinforce accountability to the treatment process.

Stages I–IV of Individual Therapy

Individual therapy in DBT can be seen through a prism of four stages: *stages I–IV of individual therapy*, which involve the following:

- **stage I:** a focus on safety and stabilization, in the following order: behaviors that are life threatening, behaviors that interfere with therapy, and behaviors that decrease the quality of life
- **stage II:** a focus on behaviors that cause misery and "quiet desperation," often due to past trauma and invalidation
- **stage III:** a focus on behaviors that cause problems in everyday living, so clients can live a life of relative contentment with its ups and downs
- **stage IV:** a focus on finding deeper meaning, spiritual fulfillment, and ongoing capacity for success and joy

When conducting individual counseling, techniques are a function of the stage in which the client is presenting at the time of treatment. Because clients who are in stage 1 are dealing with issues that are life-threatening, interfere with counseling, or decrease the quality of life, these concerns should be addressed first. Although there is generally linear movement in DBT, stages can sometimes overlap, and clients can, at times, fall back to earlier stages. The following delineates some of the guidelines and techniques used in the various stages.

Structuring Therapy

Regardless of the stage of treatment, *structuring therapy* is important and often looks like the following (Pedersen, 2015; Van Dijk, 2012):

- Greet the client warmly; ensure maintenance of the therapeutic alliance.
- Address the affective state of the client.
- Conduct mindfulness to ground client and counselor.
- Inquire about other aspects of treatment (e.g., group skills training).
- Inquire about homework assignments.
- Review diary card (see next section).
- Conduct work of the session based on acquired knowledge just obtained.
- Set goals and assign homework when appropriate.
- Conduct a final mindfulness exercise.
- Say goodbye and give an appointment reminder.

Diary Card

Most counselors who practice DBT have clients complete a daily diary card that is submitted weekly. The *diary card* helps clients focus on their emotions during the week, and if the client is experiencing suicidal or parasuicidal ideation, phone coaching is required. There are numerous versions of the diary card (Brodsky & Stanley, 2013; Moonshine & Schaefer, 2019), and a shortened version of one, for one day of the week, is shown in Table 14.2.

TABLE 14.2. Modified Example of a Diary Card

Day of Week: Monday	Diary Card				
List Strong Emotions: →	Depression	Hopelessness	Apathy	Other:	Other:
Note Strength →	(4)	(4)	(3)		
(Low = 1; High = 5)					
Urges: →	Suicide	Cutting	Other:	Other:	Other:
Note Strength →	(2)	(5)			
(Low = 1; High = 5)					
Behaviors: →	Cutting	Other:	Other:	Other:	Other:

Diary cards may track a wide range of issues, such as levels of suicidal ideation, self-injurious behaviors, treatment-interfering behaviors (TIB), levels of strong feelings (e.g., depression, anxiety, and anger), medications used, sleep, energy level, substance use, self-care skills, and more (Pederson, 2015). If a diary card is not completed during a week, a chain analysis is conducted with the client and will take the place of an individual therapy session, thus reinforcing the importance of completing the diary card.

Chain Analysis

This involves a detailed examination of a problematic behavior that needs to be addressed. Such an analysis generally examines the following items (Moonshine & Schaefer, 2019; Van Dijk, 2012):

- the problem behavior (often identified in the diary card),
- how the environment is linked to the prompting event,
- links in the chain of events between the prompting event and the problem behavior,
- negative and positive consequences of the problem behavior,
- ways to decrease one's vulnerability to the problem behavior,

- ways to prevent the prompting event from occurring again,
- ways to decrease the chain of events that led to the problem, and
- ways to correct or repair the harm—or make amends—related to the problem behavior (see Box 14.2).

BOX 14.2 Chain Analysis

Name of Client: Jeremiah Bully Picker

Problem Behavior: Skin picking (excoriation disorder)

Environmental Vulnerability: Work-related stress due to project deadline and lack of sleep

Prompting Event: Argument with partner

Links in the Chain: "I came home from work and started talking with my wife about the day. She told me that I was being nasty to her in my tone. I said I was not. She said I was not able to hear myself, and I got angry. I angrily told her she was wrong, and she said she was not. I got even more angry and got close to yelling at her that she was driving me crazy. She told me there was something wrong with me and to go away. I felt like hitting her, but smartly went upstairs to my bedroom and watched TV. At this point, I started picking at my skin. I had a few scabs on my hand and arm, and I picked them so badly they were bleeding. I looked at the bleeding scabs and felt embarrassed by what I had done and, for a moment, felt like life was not worth living. I got some Band-Aids to stop the bleeding, so I could no longer pick them. My wife came upstairs, saw what I had done, and told me she felt badly about the whole incident. She rubbed my back and told me she loved me. I told her I loved her too, and then, I took a long nap."

Negative Consequences:

1. Resulted in argument and emotional distance from wife
2. Damaged my body and felt badly about myself

Positive Consequences:

1. Wife apologized and took care of me
2. Took a nap, which made me feel better later

Ways to Decrease Vulnerability in the Future:

1. Find a stress reliever (e.g., meditation, mindfulness exercises, or working out) before coming home
2. Seek doctor for temporary pills to help me sleep
3. Seek antidepressant that also has anti-compulsive behavior effects

Ways to Prevent Prompting Event:

1. Don't go directly home after a very stressful day at work. Instead, practice a stress-reducing behavior (e.g., exercise, meditation, or mindfulness).
2. If I see an argument beginning, defuse it, or walk away and do something else.

Ways to Decrease the Chain of Events:

1. When I feel really stressed, I should recognize it and do something to alleviate it (e.g., mediation, exercise, or mindfulness).
2. If I feel really stressed, I should practice my communication skills with my wife and let her know that I am not in a good place.
3. When I see myself escalating an argument through anger, I should remove myself from the situation.
4. When I see myself escalating an argument through anger, I should be humble and explain that my anger is not a good thing to my wife.
5. When I get the urge to pick at my skin, I should immediately put Band-Aids on any scabs I have, take a tranquilizer, and/or take a brisk walk.

Ways to Correct, Repair, or Make Amends:

1. I should apologize to my wife for my anger.
2. I should explain to my wife that I am an emotional rollercoaster, I am sorry for that, and I am working on it in therapy, so we can have a better marriage.
3. I should tell myself that although I picked at my skin, I need to forgive myself, and I am working on lessening my symptoms, while accepting that I have this problem.

Dialectical Communication Skills

A variety of communication skills are used in DBT that support the dialectical strategy of acceptance and change, assist people in seeing situations in a more complex manner, and help clients consider other points of view (Linehan, 2020; Moonshine & Schaefer, 2019; Pederson, 2015; Van Dijk, 2012). Some of the most frequently used skills include radical acceptance, reciprocal communication, irreverent communication, playing the devil's advocate, using metaphors, making lemonade out of lemons, the exception rule, wise mind, role reversal, and understanding the three dialectics. Using the chain analysis example in Box 14.2, let's look at some examples of these.

- **radical acceptance:** In the tradition of some existential-humanists, this means hearing the client fully, showing empathy, and offering unconditional positive regard to the client. Here the counselor accepts that the client is doing everything they are capable of doing within their current understanding of the world.
  - Counselor: "Sounds like this whole thing was a very painful experience for you. On the one hand, you felt justified getting angry with your wife. On the other hand, you were upset at how things ended up with her and how you started to pick at your scabs."
- **reciprocal communication:** This involves a give and take conversation with the client in which the counselor is genuine, warm, egalitarian, a good listener, empathic, respectful, understanding of the client's predicament, and self-disclosing in appropriate ways. These responses are crucial to the development of the therapeutic alliance, validate the client, encourages the client to engage in conversation about their issues, and can be reinforcing of change.
  - Counselor: "I'm hearing that you had a really good experience with your partner after the argument. It shows me you have really worked on defusing upsetting situations. I know, from my own life, how good that must feel. What are your thoughts?"
  - Client: "I did feel good after we had talked things through and was more hopeful about working on my problems. Maybe we can look at my goals again."
  - Counselor: "Yes, that sounds great."
- **irreverent communication:** Whereas radical acceptance and reciprocal communication is the "yin," irreverent communication is the "yang," in that it is provocative, confrontational, and direct. It includes responses that clients might not like hearing with its purpose being to help the client see the world differently; push them off balance, so they can get rebalanced in a more positive manner; and shift their affective focus to one that's healthier.
  - Counselor: "I thought we agreed to abide by your contract for therapy, yet this past week when you got angry at your partner you ended up picking the scabs on your arm. That certainly was not in the contract."
  - Client: "Yes you're right. I need to remember to practice my meditation and other skills that I have learned here so that I don't get so upset. I need to be more intentional. I don't like it when I get that way."

- **playing the devil's advocate:** Here the counselor suggests a different perspective than what the client is suggesting. This allows the client to reexamine what they are doing. It reminds the client that, "an idle brain is the devil's workshop."
  - Counselor: "Well, you're telling me you don't want your anger to take over when you are with your partner, but I think I'm hearing that when you get into it with her, there are some secondary gains that are reinforcing. For instance, it sounds like you like the feeling of being in control and proving yourself right."
- **using metaphors:** A metaphor offers an alternative mechanism for clients to understand their problem and is processed by the brain in a different manner than a traditional counselor response. It, thus, offers an opportunity for clients to understand their situation in a new way.
  - Counselor: "You certainly left that situation like a lightning bolt. As soon as you realized it was not healthy, you removed yourself from that toxic place. Good job!"
- **making lemonade out of lemons:** This technique takes a problem situation and turns it into a potential positive experience.
  - Counselor: "The argument with your wife, and the eventual picking really gave you an opportunity to practice those skills that you learned!"
- **the exception rule:** Borrowed from solution-focused brief therapy (SFBT), this technique has clients consider times when problematic behaviors were not in a person's life, so they can identify the context in which it was occurring and try to replicate it.
  - Counselor: "So we talked about times when you did not feel inflicted with the need to pick at your skin. Can you tell me what was going on in your life then that was different than now?"
- **the wise mind:** This is when the counselor asks an emotionally activated client to consider a situation from their wise mind. The wise mind is the place between the logical mind and emotional mind. It is accessed when the client can obtain a deeply meditative or aware state that allows them to contact a personal place in which they can recognize feelings and respond to them rationally.
  - Counselor: "Right now, you are really upset and convinced that your partner wants to constantly irritate you. But let's try accessing your wise mind for a moment. Breathe in and out, focus on your body, and consider the situation. Let yourself be in your body for a moment. Go deep inside yourself, as if you are observing your emotions and the situation. Now, using your wise mind, reflect on the situation, and consider whether you think your partner wants to constantly irritate you?"
- **role reversal:** This is asking the client to take on the role of a person with whom there are ongoing problems, so the client can see a different perspective on the problems.
  - Counselor: "Can you talk to me like you are your wife. From her perspective, what would she tell me about the fight you had?"
- **understanding the three common dialectics:** As noted earlier, clients in DBT are often struggling with one or more of the polarities of active passivity/apparent competence, emotional vulnerability/self-invalidation, and unrelenting crisis/inhibited grieving. Stuck on one side of the polarity or bouncing back and forth between the polarity, they maintain a type of rigidness in their approach to the world. Through psychoeducation and encouragement, counselors can help clients understand the polarity they are struggling with and move them toward integration of the two sides.

- Counselor: "So as we have talked before Jeremiah, one of your fallback positions is emotional vulnerability, which quickly turns into self-invalidation. Look at how you quickly get upset at your wife and then want to discount your feelings and yourself. You even say maybe 'Life isn't worth living.' And then you want to ignore your emotions, and you start to self-pick. Can you think of other ways you could have handled that situation without reacting so strongly followed by self-injury?"

Behavioral Skills

Core to change in DBT is its focus on behavioral techniques. Thus, any DBT counselor should be familiar with the basics of operant conditioning, classical conditioning, and modeling, or first-wave behavioral techniques. DBT counselors often perform a *functional behavior analysis* to identify the contingencies involved when a behavior is reinforced. A *chain analysis*, discussed earlier, is a type of functional analysis of behaviors. For instance, if we were to look at Jeremiah's chain analysis in Box 14.2, we could begin to see the reinforcement contingencies involved in some of his behaviors:

- **stress related to project deadline and lack of sleep:** better time management and intentional sleep-inducing behaviors can be positively reinforcing, as Jeremiah experiences less stress and is positively reinforced for his work habits
- **negative tone of wife (perceived by husband) and wife telling him there is something wrong with him and to go away:** attempts at punishment by wife results in husband feeling badly, becoming emotionally dysregulated, and leaving the situation
- **picking at skin:** skin-picking behavior releases endorphins, which are addicting and reinforces the behavior. The compulsive behavior then becomes classically conditioned, as it is associated with a decrease in anxiety and anger.
- **placing Band-Aids on bleeding scabs:** extinction technique of response block
- **wife rubbing his back and telling him she loved him:** positive reinforcement of chains, potentially reinforcing similar behaviors in the future.

This functional analysis of Jeremiah's behaviors offers several opportunities for behavioral interventions. For instance, by encouraging better time management, in the future Jeremiah can space out his work project and be positively reinforced for his work habits. Intentional sleep-inducing habits can also reduce stress, which will result in better work habits and increase positive reinforcement. In addition, mindfulness, or many of the other skills learned in group skills training, can be used to lessen his stress when he comes home. Jeremiah can also learn to identify possible negative consequences of his interaction with his wife and take preemptive measures when he returns home. Such skills lessen the likelihood of his wife punishing him for his behaviors and increases chances of positive communication between the two of them. He could also practice, with his wife, new interpersonal skills he has learned in group skills training and avoid certain interactions with her (e.g., take a nap immediately when he gets home, read a book, or watch TV). Preemptively placing Band-Aids on scabs can lessen the likelihood of picking and the immediate reinforcement he obtains from the release of endorphins. Rubbing your partner's back may feel good but should not be done when it reinforce a series of negative behaviors. Can you think of other behavioral interventions that can be done in any of the links just cited (see Box 14.3)?

BOX 14.3 Behavioral Responses to Jeremiah

Take a look at the links identified in Jeremiah's chain analysis and come up with three behavioral interventions that will lessen the likelihood he will get into an argument with his wife and/or skin pick. Share with others.

1. _____.
2. _____.
3. _____.

Behavioral techniques are powerful ways of changing behaviors and can be used in many ways in DBT. For instance, the counselor can model effective behaviors, reinforce positive behaviors of the client, teach the client how to use self-management techniques to reinforce positive behaviors, teach other people in the client's life to reinforce positive behaviors, and more.

Cognitive Skills

Whereas traditional cognitive therapies view thoughts as something that need to be replaced or disputed, in DBT thoughts are one additional mechanism that can increase cognitive complexity and help a client consider other points of view (Pederson, 2015). But first, and critical to the DBT process, the counselors must validate and accept the client's current cognitive perspective, as it is assumed that it makes sense within the client's current contextual framework (e.g., their biological, behavioral, and cognitive makeup). It is also important to not attempt to expand a client's perspective when they are emotionally dysregulated, as emotionally unregulated people tend to be locked into their cognitive distortions.

Pedersen (2015) identifies *14 cognitive distortions* that individuals sometimes embrace and suggests the dialectical shift they can be encouraged to take. They include the following:

- **black and white thinking:** believing things are always one way
  - **dialectical shift:** Consider other or opposite points of view.
- **regret orientation:** having ongoing remorse about the past
  - **dialectical shift:** Focus on current change one can make.
- **mind reading:** assuming you know what others are thinking
  - **dialectical shift:** Checking out assumptions with others.
- **minimization/magnification:** making a large concern very small or small concern very large
  - **dialectical shift:** Examine a concern carefully and fully before responding, as a check on its accuracy.
- **catastrophizing:** making a situation much worse than it actually is
  - **dialectical shift:** Focus squarely on a situation, and work it, while remembering most situations do not end in catastrophe.
- **fortune-telling:** predicting the future negatively
  - **dialectical shift:** Focus on current problem-solving techniques.
- **overgeneralizing:** generalizing too broadly
  - **dialectical shift:** Get facts and check out assumptions for all situations.
- **selective information gathering:** filtering information, so it reinforces current thinking
  - **dialectical shift:** Gather information from alternative points of view.
- **labeling:** making a person or situation a label (e.g., "You're a borderline personality")
  - **dialectical shift:** Describe behaviors or the context of situation in nuanced ways.

- **personalization:** always making situations about you
  - **dialectical shift:** Decipher what is, and what is not, about you, and don't take situations too personally.
- **emotion mind reasoning:** not using reason; always infiltrating thoughts with emotions
  - **dialectical shift:** Use mindfulness and other skills to access one's wise and rational mind.
- **should statements:** judging the situations and assuming they will unfold in a certain way
  - **dialectical shift:** Allow situations to unfold naturally, and examine what is, not what should be.
- **discounting positives:** focusing on negatives and downplaying positives
  - **dialectical shift:** Embrace the positives.
- **blaming:** assuming others are responsible for our actions and problems
  - **dialectical shift:** Take responsibility for one's own actions and problems.

Group Skills Training

Group skills training consists of four modules—*mindfulness*, *distress tolerance*, *emotional regulation*, and *interpersonal effectiveness*—and has a curriculum that spans 24 weeks, which is often duplicated to create a yearlong program (Linehan, 2015a). Whereas mindfulness and distress tolerance skills are types of acceptance skills, emotional regulation and interpersonal effectiveness skills are types of *change skills* (Figure 14.3).

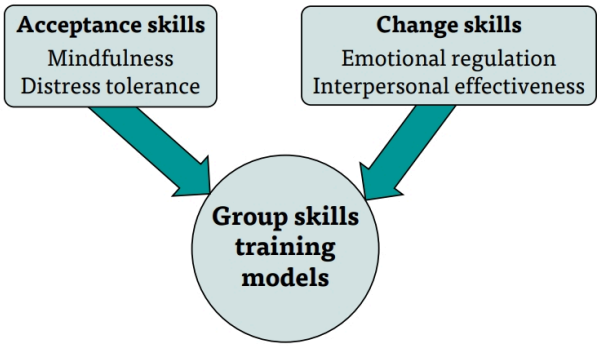

FIGURE 14.3 Acceptance and Change Skills

DBT skills are taught in order and divided into four sections: "(1) a beginning ritual, (2) review of homework practice since the last session, (3) presentation of new material, and (4) a closing 'wind-down'" (p 54). For instance, a session could begin with a mindfulness exercise, followed by the group members sharing their attempts at working on their homework, followed by the skills trainer presenting a new behavioral skill, and ending with a wind-down discussion in which each participant shares what they observed during the session. Group members are strongly encouraged to stay on topic and not talk about issues unrelated to the skills being taught.

Linehan (1993b, 2015a) created three hierarchical goals, or priorities, that are worked toward in skills training: (a) stopping behaviors that very likely will destroy therapy, (b) acquisition, strengthening, and globalization of skills, and (c) reducing behaviors that interfere with therapy. Most of the skills are taught in a specific order. If a client misses one module, they can make it up; however, skills training requires participation in all modules and ongoing practice of these skills.

It is critical that the skills learned in group are reinforced in individual counseling and during phone coaching. Therefore, near the beginning of each individual therapy session the counselor will inquire what the client has learned during their group sessions and if the client had followed through on practicing new skills during the week. Similarly, during phone coaching, counselors can remind clients of the skills they have learned, how to apply them, and positively reinforce clients if they have practiced their skills during the week. In this case, practice makes perfect, and *reinforcement of group skills training* by the counselor and others in the client's life can help ensure the skills become a natural aspect of the client's way of being. The following is a brief overview of the four modules: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness techniques.

Mindfulness (Acceptance Skill)

> Mindfulness is not a place we get to. Mindfulness is a place we are. (Linehan, 2015a, p. 152)

Drawing from her experiences with deep prayer and Zen Buddhism, Linehan incorporated *mindfulness* into DBT (Linehan, 1993a; 1993b; 2015a, 2020). Mindfulness helps clients be present to their experience, listen nonjudgmentally to themselves, and become a neutral observer of what is happening internally and externally. Whereas meditation can be a type of mindfulness, mindfulness does not have to be meditative. Mindfulness is a way of living that occurs on an ongoing basis. It allows a person to become one with the moment, as they observe oneself experiencing life.

Linehan (2015a) describes the "What?" and "How?" skills of mindfulness. *What skills* involve observing events, emotions, and behavioral responses without labeling or terminating them—even when they are unpleasant, "describing" observed physical and environmental events by applying verbal labels to them and "participating" in activities fully, without self-consciousness. How skills describe the process of observing, describing, and participating in mindfulness. This involves being "nonjudgmental" in one's evaluation of self; being "one-mindful," or focusing one's attention on the task at hand; and being "effective," which is to say letting go of a need to prove a point or demonstrating that one is right or one is wrong (Box 14.4).

Mindfulness can help clients experience where they are in the moment and make decisions about where they want to go. Pederson (2015) suggests that individuals who are struggling in life but are not in deep pain may use mindfulness to understand their current state of being, eventually deciding to accept their situation or set goals to change. On the other hand, those in deep pain may decide, rather than focusing on their pain, to shift their attention to something else, such as a task, a deep-breathing exercise, or something positive in their lives.

BOX 14.4 Mindfulness Exercises

Here are a few very quick mindfulness exercises you can practice. Remember, mindfulness allows one to have acute awareness, while being nonjudgmental and accepting of whatever comes into consciousness. While doing this exercise, you should observe, describe, participate fully, be nonjudgmental, be one-mindful (focused on the task), and be effective (don't try to prove a point):

- **Observe a flower or a leaf.** Hold a flower or leaf in your hand and look at it. Describe the leaf to yourself as if you are observing it for the first time.
- **Observe your thoughts.** Sit comfortably and close your eyes. Let your thoughts wander and observe where they are. Do not judge or critique them, just observe them.
- **Observe your feelings.** Sit comfortably and close your eyes. Allow yourself to experience any emotions you are having without your thoughts about them getting in the way.
- **Eat mindfully.** While having a meal, observe and describe to yourself what you are eating and how you are eating. Allow yourself to fully engage in eating without evaluating the food or yourself and focus on the process of eating.
- **Listen mindfully.** Sit with a person and listen acutely to what they have to say. Do not judge. Do not jump in and give advice. Do not critique the person to yourself. Just allow yourself to hear the other person fully. Periodically, paraphrase back what the person has said to you, so they can continue to speak.

When you have finished one or more of the exercises, talk with others about what you may have learned through the mindfulness exercises. How was it different, if at all, from how you usually experience yourself or others? Consider how mindfulness can be helpful in accepting or changing symptoms?

Distress Tolerance Skills (Acceptance Skills)

DBT theory believes it is important to be able to tolerate a crisis, endure pain skillfully, accept and find meaning in distressing events, and not act impulsively during a crisis (Linehan, 1993a, 2020). To achieve these goals, DBT teaches a multitude of distress tolerance techniques within two overarching modules: crisis survival skills and reality accepting skills.

Crisis survival skills are short-term solutions used to help tolerate painful situations and lessen the likelihood of a client acting impulsively (Linehan, 2015a). The six survival strategies are the following:

1. **STOP skills:** This stands for stop, take a step back, observe, and proceed mindfully.
2. **pros and cons:** Here clients consider the positive or negative consequences of acting, or not acting, on their impulses.
3. **TIP skills:** These exercises are used to change body chemistry to lessen emotional arousal. TIP stands for temperature, intense exercise, paced breathing, and paired muscle relaxation.
4. **distracting with wise mind ACCEPTS:** These distracting methods reduce contact with emotional stimuli. ACCEPTS is defined as "[a]ctivities (discordant to the negative emotion), [c]ontributing, [c]omparisons, [e]motions (opposite to the current negative emotion), [p]ushing away from the situation, [t]houghts, and [s]ensations" (Linehan, 2015a, p. 417).
5. **self-sooth:** This involves using activities that help soothe the senses of vision, hearing, smell, taste, and touch.
6. **IMPROVE the moment:** This involves focusing on the following items to improve the quality of life: "[i]magery, [m]eaning, [p]rayer, [r]elaxing actions, [o]ne thing in the moment, [v]acation, and [e]ncouragement" (Linehan, 2015a, p. 417).

Reality accepting skills are those used to reduce the suffering that is associated with crisis and increased freedom for individuals when painful situations cannot be changed. Linehan (2015a) has developed reality accepting skills, which include the following:

1. **radical acceptance:** This is the complete and total acceptance of the facts of reality.
2. **turning the mind:** The first step toward acceptance, it involves "turning the mind" toward acceptance. This is a skill that takes time to develop; it must be practiced over and over again.
3. **willingness:** This is the surrendering to, and immersing oneself in, the process of life. It is contrasted with willfulness, which is trying to direct life.
4. **half-smiling and willing hands:** These exercises assume that our muscles reflect, or reject, acceptance. Half-smiling is the practice of relaxing facial muscles and turning the lips slightly upward, while willing hands is the practice of unclenching hands and keeping palms and fingers relaxed.
5. **mindful of current thoughts:** This skill is aimed at having clients practice observing their thoughts as a brain function that involves neural firings, not necessarily thoughts that hold truth or are absolute facts about one's life. This helps to make client's thoughts less reactive.

Emotional Regulation Techniques (Change Skills)

Dysfunctional emotion regulation can lead to a wide range of serious behavioral problems, such as substance abuse, self-harming practices, overeating, overcontrol, and emotional suppression

(Linehan, 2015a, 2020). Thus, emotional regulation techniques are used to proactively decrease emotional dysregulation and develop positive emotions. To work on emotional regulation, Linehan suggests it is important for clients to understand and name emotions, change unwanted emotions, reduce vulnerability to the emotional mind, and manage extreme emotions.

- **understanding and naming emotions:** Emotions help us communicate with others about our state of being, alert us to something that is happening ("I'm scared!"), and are signals to how we might want to control and influence behaviors. If we are to respond realistically to our emotions, *understanding and naming emotions* becomes critical and is easier to do if we can "observe and describe (1) the event prompting the emotion; (2) the interpretations of the event that prompted the emotion; (3) the history prior to the prompting event that increases sensitivity to the event and vulnerability to responding emotionally; (4) the phenomenological experience, including the physical sensation, of the emotion; (5) the expressive behaviors associated with the emotion; and (6) the aftereffects of the emotion on other types of functioning" (Linehan, 2015a, p. 319).
- **changing unwanted emotions:** Once we are clear on what emotions we are struggling with, we can begin the process of changing them, which can happen in numerous ways. For example, one can use mindfulness to experience the primary emotion. This prevents secondary emotions, which exaggerate the dysfunctional emotional state (e.g., guilt about the emotion), from being exhibited and results in an uncomfortable, but tolerable, situation. Also, a person can practice opposing an emotion and try to exhibit a different, less toxic emotion. Changes in facial expressions and posture can also help elicit different emotions from a person. One other technique would be to purposely set out to increase pleasurable experiences in one's life that would lead to more positive emotions.
- **reducing vulnerability to the emotional mind:** In this block of skills training, a client learns to manage emotions by acquiring positive emotions, taking care of his or her physical body, building skill mastery, and learning how to cope prior to difficult situations. Positive emotions can be built in multiple ways. For instance, individuals can surround themselves with more pleasurable experiences or valued events that result in increased daily positive experiences and create a life worth living. Increasing positive emotions increases resiliency, thus making it easier to handle negative experiences. Also, a number of basic activities can help an individual feel better and reduce emotional dysregulation. For example, eating healthy, getting enough sleep, getting exercise, dealing effectively with illnesses, not using illicit drugs, and acquiring other healthy habits can all help to build skill mastery, are preventative measures for difficult situations that may arise, and increase self-efficacy.
- **managing extreme emotions:** Extreme emotions can occur in any person's life but are more frequent with those who have BPD or related disorders. One method of lessening an extreme emotion is by mindfully attending to one's current emotions without judgment, inhibitions, or distractions. This results in the lessening, or extinguishing, of secondary emotions (e.g., shame and guilt), which leads to the ability to attend to the primary emotion. At this point, one is more likely to find the primary emotion to still be extremely annoying but tolerable.

Interpersonal Effectiveness Skills

Linehan (1993b, 2015a, 2020) believes most people have reasonably effective interpersonal skills but lack the ability to employ them effectively. Thus, through group skills training, a client learns how to strengthen and use interpersonal skills. Three kinds of interpersonal effectiveness techniques

are: (a) obtaining objectives while maintaining relationships and self-respect, (b) building relationships and ending destructive ones, and (c) walking the middle path:

- **obtaining objectives while maintaining relationships and self-respect:** These skills teach individuals how to get what one needs, how to say no, and how to effectively manage interpersonal conflicts. Linehan (2015a) has outlined nine specific skills training modules that work toward this core skill.
  - **modules 1–4:** Here the focus of skills training is on identifying factors that are interfering with one's interpersonal effectiveness.
  - **module 5:** This focuses on how to obtain one's wants through the mnemonic DEAR MAN: describe, express feelings, assert wishes, reinforce, (stay) mindful, appear confident, and negotiate.
  - **module 6:** This focuses on relationship effectiveness skills that are taught with the mnemonic GIVE: (be) gentle, (act) interested, validate, (use an) easy manner.
  - **module 7:** For this module, group members learn skills to keep one's self-respect and uses the mnemonic FAST: (be) fair, (no) apologies, stick to values, (be) truthful.
  - **module 8:** Here the group works on the intensity one uses when asking for what the client wants and learning what intensity to use when saying no.
  - **module 9:** This module focuses on troubleshooting or looking at where the client fails in their interpersonal effectiveness skills and why.
- **building relationships and ending destructive ones:** The second section of interpersonal effectiveness techniques focuses on developing and maintaining relationships and on ending relationships that may be damaging or destructive. Here Linehan (2015a) outlines three modules:
  - **module 1: finding potential friends:** The first set of skills focus on individuals becoming active participants in finding others who might become friends.
  - **module 2: mindfulness of others:** Here group members learn how to be sensitive and nonjudgmental of others and how to describe their own thoughts, feelings, and reactions without being blaming or critical of others. Using mindfulness techniques can help a person respond in such ways.
  - **module 3: how to end relationships:** Now that the trainer has taught the skills needed to actively find friends and being mindful of others, the group moves to learning how to effectively end destructive and damaging relationships. Linehan believes that staying in damaging relationships for too long is just as impactful as not having any relationships.
- **walking the middle path:** Originally developed for work with adolescents and their caregivers, these skills have been found to also be critical for adults (Linehan, 2015a). They include teaching dialects, validation, and strategies for changing behavior.
  - **module 1: dialectics:** Here clients are taught how behavior is in the moment and also how it impacts the broader system; how reality is made up of polarities (e.g., change and acceptance); how rigid, dualistic thinking prevents individuals from changing; and that change is continuous throughout life.
  - **module 2: validation:** Group members in this module learn how to overcome invalidation, how to validate themselves, and the importance of validation in interpersonal relationships.
  - **module 3: strategies for changing behavior:** This is where several behavioral skills are taught, including a wide variety of operant conditioning techniques and how behaviors are contingent on one another. These are the same kinds of skills that counselors use when assisting in behavioral change processes.

Consultation Team Meetings

The third mode of dialectical behavior therapy is the *consultation team meeting*. This is a weekly meeting, lasting, on average, 60 to 90 minutes and consisting of two to eight professionals (Linehan, 2015a). For example, a consultation team might be composed of a licensed psychiatrist, licensed counselor, and group skills trainer.

Linehan describes the job of the consultation team as "therapy for the therapist by the therapist" (Linehan, 2015b, 47:30). Therapy for the counselor is important, as working with clients with BPD, or a related disorder, can be extremely taxing. Consultation team meetings allow all those involved in treatment to coordinate with one another about the treatment plan and helps to ensure that all involved are on the same page. In addition, skills learned in group can be reinforced in individual therapy, and vice versa, and these skills can be discussed in the consultation team meeting. Like clients, treatment team members commit to consultation team meetings, and if they miss meetings the team tries to address the consultation-interfering behavior. If they continue to miss, the provider should no longer state they are a DBT counselor (Swales & Heard, 2017).

Between-Session Coaching

In DBT, *between-session coaching*, usually by phone, is an ongoing treatment mode incorporated into the therapeutic process. *Phone coaching*, which is focused mostly on skills training and reinforcement of newly learned skills, is time-limited and has specified rules that are set when the counselor–client contract is developed. Clients are also told that they *must* call to obtain assistance in practicing the skills they learned prior to any self-harm they are considering. Linehan (1993a, 2015a, 2020) suggests that, in addition to reinforcing skills training, phone coaching can help build the therapeutic alliance, offer an additional venue in supporting clients when they are in distress, reinforce new behaviors, and offer more immediate help when a client is struggling with an interpersonal conflict.

Linehan (2015b) states that she added this component to DBT because she found it unfair that the counselor had so much control over the client's time. Although available, phone coaching is not a 24/7 access line for the client but an added form of communication, which has limits set at the discretion of the counselor. This can be done by setting rules on availability, such as taking phone calls Monday, Wednesday, and Fridays from noon to 4 p.m. Other boundaries may also be set. For instance, if a client does not uphold proper phone etiquette (e.g., hangs up on the counselor), then they are not allowed to phone the counselor for a week.

Summation of Techniques Section

DBT contains five components: the pretreatment change, the four stages of individual therapy, group skills training, consultation team meetings, and between-session coaching (e.g., phone coaching). These components work hand in hand, as the client moves from a more crisis-oriented, emotionally dysregulated state marked by destructive behaviors and cognitive rigidity to an ability to moderate their emotions and think in more complex and relativistic ways. Along this path, while in group skills training, the client learns a number of specific techniques and ways of living in the world that are reinforced in individual therapy, and vice versa. Phone coaching is available for clients who need emotional support between sessions and offers clients an opportunity to connect with their counselor during the week and fine-tune some of their newly learned skills. Consultation team meetings occur weekly, so the treatment team members can consult with one another about the treatment plan and provide support regarding their work with clients. Table 14.3 summarizes some of the skills taught and goals achieved in the various modes of DBT.

TABLE 14.3. Skills Achieved and Goals Attained in DBT Modes

Pretreatment Stage	• orientation and commitment • assessment • psychoeducation • explanation of the purpose and process • boundaries of the relationship • verbal or written agreement			
Individual Therapy (Stages I–IV)	• **structuring therapy:** building an alliance, addressing affect state, conducting mindfulness, inquiring about treatment (e.g., group skills), inquiring about homework, reviewing the diary card, conducting the session, setting goals and homework, and saying goodbye			
	• **diary card:** focusing on emotions, suicidal ideation, self-injurious behaviors, strong feelings, and—sometimes—medications, sleep, energy level, substance use, self-care, and more			
	• **chain analysis:** identifying problem behavior, environmental vulnerability, prompting event, links in chain, negative and positive consequences, ways to decrease vulnerability, ways to decrease chain, and ways to correct, repair, or make amends			
	• **dialectical communication skills:** radical acceptance, reciprocal communication, irreverent communication, playing the devil's advocate, using metaphors, making lemonade out of lemons, the exception rule, wise mind, role reversal, and understanding the three dialectics			
	• **behavioral skills:** functional analysis, chain analysis, operant conditioning, classical conditioning, and modeling (first-wave behavioral techniques)			
	• **cognitive skills:** making dialectical shifts from one's cognitive distortions (see 14 types of cognitive distortions listed)			
	• **reinforcing group skills training:** practicing and reinforcing skills learned in the group			
Group Skills Training	*acceptance skills*	mindfulness	what skills	observing, describing, and participating
			how skills	being nonjudgmental, one-mindful, and effective
		distress tolerance	crisis survival skills	• stop skills • pros and cons • tip skills • distracting with wise mind accepts • self-sooth • improving the moment
			reality acceptance skills	• radical acceptance • turning the mind • willingness • half-smiling and willing hands • mindful of current thoughts

(Continued)

TABLE 14.3 (*Continued*)

	change skills	emotional regulation techniques	• understanding and naming emotions • changing unwanted emotions • reducing vulnerability to the emotional world • managing extreme emotions
		interpersonal effectiveness techniques	• **modules 1–4:** factors interfering with interpersonal effectiveness • **module 5:** how to obtain wants—"dear man" • **module 6:** effective skills—"give" • **module 7:** self-respect—"fast" • **module 8:** working on intensity of communication • **module 9:** trouble shooting—failures in communication
Consultation Team Meetings	• consists of counselor, group skills trainer, psychiatrist, and others • "therapy for the counselor" • coordination of treatment and skills		
Between-Session Coaching	• helps build therapeutic alliance • helpful in stopping suicidal or self-harming behaviors • helpful in reinforcing skills learned • helpful in offering immediate help when a conflict arises		

The Counseling Process

> The first thing with getting behavior under control is keeping them [clients] alive because I guarantee you, therapy does not work for dead people. (Linehan, 2015b, minute 24:54)

DBT was originally developed for individuals with BPD, but in recent years it has been expanded to related disorders and even to other problem behaviors. Clients who initially see a DBT counselor first participate in a pretreatment stage in which the counselor and client jointly agree whether this type of therapy is the best approach for the client. During the pretreatment stage the counselor explains the purpose and process of DBT and orient the client to DBT. Early on in this stage, the counselor conducts an assessment and identifies a diagnosis. Psychoeducation about the client's diagnosis, the biosocial model, emotional dysregulation, dialectics, the therapeutic process of DBT, and more are explained. The client then decides whether they are ready to commit to the rigorous DBT process.

If the client agrees to undergo DBT, they are committing to six months to one year, or more, of treatment, which involves a combination of individual counseling, group skills training, and periodic between-session coaching. After assessing and dealing with any self-harm or therapy-interfering behaviors, each individual counseling session is structured in a similar manner. Here clients do mindfulness activities, talk about progress in group skills training, discuss any homework assigned, review their diary cards to address how they are doing in their lives, set goals and obtain homework (based, at least in part, on the diary card), conduct a final mindfulness exercise, and set a time for the next appointment.

In addition to individual therapy, clients undergo group skills training during the week. During these trainings, they learn various acceptance techniques (e.g., mindfulness and a variety of distress tolerance techniques) and a number of change techniques (e.g., emotional regulation and interpersonal effectiveness skills). These skills are practiced in group and reinforced in individual counseling.

During the week the client has an opportunity to contact the counselor, often via phone, to discuss any problematic behaviors or to fine-tune newly learned skills. Meanwhile, the counselor meets with the group-skills trainer, and probably a psychiatrist or other treatment team members, to discuss progress and any issues that might interfere with their ability to work with the client and to offer support to one another. Over the course of therapy, clients learn new behaviors, develop more flexible ways of thinking, and apply a variety of acceptance and change techniques that help to moderate their emotional dysregulation and live a life that is a less chaotic, emotionally moderated, and more joyful.

Social, Cultural, and Spiritual Issues

Relative to cross-cultural counseling, DBT has been shown to be applicable across the lifespan, including children as young as age 7 and older adults (Behavioral Tech, 2021a). Suitable for individuals from any sexual orientation, gender, race, ethnicity, and from most cultures, DBT has been implemented globally in more than 30 countries for a wide range of diagnoses.

Some DBT components, such as mindfulness, dialectics, wise mind, and nonjudgmental acceptance, are rooted, and evident, in spiritual practices. For example, Binensztok et al. (2018) note that the centering prayer in Judeo–Christian practice closely parallels the practice of mindfulness of Zen Buddhism and other Eastern philosophies. Thus, the attention to and acceptance of a present moment in DBT may be familiar for clients who identify as religious or spiritual.

Another example of potential spiritual alignment is that of DBT's dialectical philosophy, or the acceptance and balancing of polarities of one's life experiences. For example, Christianity extols the notion of a loving and redeeming God who accepts individuals as both righteous and sinners (Wang & Tan, 2016). Thus, the acceptance of self "as one is" within a context of helping a person change is found in both DBT and spirituality and, thus, may resonate for clients who identify as spiritual. In addition, the DBT concept of wise mind that embraces the integration of rationality/cognition and emotion is congruent with some scripture (Wang & Tan, 2016).

Despite being used worldwide, in many countries health care is limited, and finding a counselor—no less, a treatment team—would be difficult (World Health Organization, 2022). Also, in economically disadvantaged countries, paying for, or having government funding of, a whole treatment team would be burdensome. Although adaptations can be made, one has to wonder whether such changes would detract from the effectiveness of DBT.

Despite its compatibility with many religious and spiritual approaches, Linehan's incorporation of Zen Buddhist practices, dialectics, and Western practices (e.g., behaviorism) can represent a challenge for individuals across many cultures. How individuals come to understand self and others varies (Kessel et al., 2014), and some individuals may come from a culture that eschews traditional Western practices, while others may feel simply feel uncomfortable about the use of Eastern practices of Zen Buddhism and its related technique of mindfulness. In addition, the notion of practicing nonjudgment can be especially difficult for some clients who may have been socialized early in their lives to automatically apply a moral lens or judgment to their and others' behavior (Wang & Tan, 2016). Thus, when working with all clients, an understanding of their ethno–psychological makeup is crucial, and appropriate cultural adaptations need to be made (Bernal et al., 2009; Ramaiya et al., 2017).

To address these cross-cultural challenges, researchers have created adaptations of DBT when working with a variety of individuals from different cultural backgrounds (e.g., Cheng & Merrick, 2017; Mercado & Hinojosa, 2017). Such adaptations should be carefully tailored to the individual and culture at hand, based on differences in beliefs and values, communication differences, whether a client comes from a collectivist culture, and the religious and spiritual values of the client. Such cultural adaptations make DBT more accessible to a larger group of diverse clients; however, they may have a negative impact on the outcomes of DBT (Ramaiya et al., 2017). Although DBT is a relatively new approach to therapy, it already has a wide body of knowledge showing its efficacy. Cross-cultural efficacy is still in question, however, and as more studies are completed, whether DBT works with a wide variety of clients will be assessed.

Efficacy of DBT

DBT is considered the best-researched treatment for BPD, and its practice has extended to treat a wide range of conditions beyond BPD (Wang & Tan, 2016). The goal of DBT is to teach clients skills they can use to regulate their emotions and eliminate maladaptive behavior. Therefore, it is not surprising that DBT has been shown to decrease suicide attempts by 59% and psychiatric hospitalizations for potential suicide by 73% and is efficacious with managing suicidal ideation and behavior, self-injury, depression, anger, emotional dysregulation, and anxiety (Behavioral Tech, 2021a, 2021b). And as one might expect, it seems to be one of the best treatments for BPD.

Evidence has also demonstrated that DBT is often more effective and less costly than treatment as usual (TAU), which may include psychotherapy, medication, or a fusion of both (Behavioral Tech, 2021a). DBT has also been shown to be effective in treating individuals with dual diagnoses (Behavioral Tech, 2021a; Harned et al., 2012, 2014).

Behavioral Tech (2021b), a Linehan Institute Training Company, notes that there have been "30 randomized controlled trials (RCTs)—the gold standard for health intervention research—produced by nearly 20 independent research groups in nine countries have demonstrated the effectiveness of DBT" (Section Recognition for DBT section, para. 1). In fact, Behavioral Tech (2016a) lists 21 randomized controlled/comparative studies that show the efficacy of DBT with individuals of a wide range of age groups and disorders that include such issues as the following:

- BPD, including those with co-occurring:
  - suicidal and self-harming behavior
  - substance use disorder
  - posttraumatic stress disorder
  - high irritability
- cluster B personality disorders
- self-harming individuals with personality disorder
- attention deficit hyperactivity disorder (ADHD)
- posttraumatic stress disorder related to childhood sexual abuse
- major depression, including:
  - treatment of resistant major depression
  - older adults with chronic depression and one or more personality disorders
- bipolar disorder
- transdiagnostic emotion dysregulation
- suicidal and self-harming adolescents
- preadolescent children with severe emotional and behavioral dysregulation
- binge-eating disorder
- bulimia nervosa

Similarly, 40 nonrandomized controlled studies list how BPD may be effective with a large range of diagnoses that are mostly related to emotional dysregulation (Behavioral Tech, 2016b). It seems pretty clear that DBT is an up-and-coming counseling approach that provides hope for individuals with BPD and other disorders related to emotional regulation.

The Millers

The following shows Jake going through DBT. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Jake's Experience With a DBT Counselor

Jake is seeing Dr. Duhamel, a DBT counselor, for three weeks now. Initially, Dr. Duhamel did a thorough assessment of Jake's situation and came up with a diagnosis of generalized anxiety disorder and a secondary diagnosis of panic disorder. It was also clear that Jake has struggled with related symptoms since childhood. Although he has had periodic respites from the symptoms, they often reoccur—and when they do, he experiences little control over them and becomes particularly reactive. After conducting the assessment and explaining the biosocial model to Jake, Jake agreed to give DBT six months. Jake meets with Dr. Duhamel weekly and also meets for 2–2.5 hours weekly with a group skills trainer and five other clients who are also in DBT therapy. Here they learn a number of skills they can use to accept themselves, regulate their emotions, and change. Also, phone coaching to practice and reinforce skills is available at designated times during the week should Jake need it. We pick up at Jake's third session with Dr. Duhamel.

Jake arrives to his individual counseling session looking frazzled and exhausted. Dr. Duhamel notices Jake's wrinkled shirt along with his unkempt hair and beard and greets him warmly. As Jake sits, he apologizes. "I am so sorry for being late. I'm not sure what happened. I set three alarms because I didn't want to be late again. I'm so sorry—I'm just a loser." Dr. Duhamel replied with a smile, "It sounds like you had quite the morning. I'm glad you made it to counseling today. Can you tell me a little more about what is going on?"

"I'm just not myself anymore, and I don't know why," replied Jake. "I don't know who I'm becoming. I've rarely been late to work, since I've been at my job, but I'm now constantly late to my meetings, to my counseling sessions, to everything. I'm barely sleeping and I'm losing it. There, I said it. I'm losing it and I'm disappointing others—even you." Dr. Duhamel patiently nods and assures him, "You've been through a lot in the past and particularly recently. This can be a difficult curve ball to manage. And, as you know, the skills that you are learning in group, and being reinforced here, are critical if you are to gain a sense that your life is moving forward." Jake nods in agreement.

Dr. Duhamel then switches gears, and says, "Before we do anything else, let's do a quick mindful breathing exercise, Jake." Jake replies with an "Okay," and with the counselor's guidance, the two men practice mindful breathing. When they finish, Jake slowly opens his eyes and says, with brief laughter, "I've been trying to practice mindful breathing at home like I've learned in group and practiced here. It always seems easier when I have a guide."

"You know, Jake, I appreciate that you've been trying at home," said Dr. Duhamel. "That shows a lot of commitment and hope, and I understand when you're under stress, it can be difficult to do. Remember, when you practice mindfulness to observe yourself and the actions around you without judgment—almost as if you are watching yourself in a movie. Don't forget, it's important not to judge yourself or others. You know, there's an app you can use that can help guide you. I can give that to you later. That might help when you feel like you're getting out of control."

"Okay, sure—that might be helpful," says Jake.

Dr. Duhamel then suggests to Jake that they review his diary card, which Jake dutifully filled out every day and brought in for his individual session. As they review it together, Dr. Duhamel notes how almost every day Jake's frustration level is very high (a 5 out of 5), and his anger is usually associated with it (usually a 4). He also notes periodic moments of panic, which are always rated a 5. Jake also records on this diary card that he is sleeping very poorly. "Well, first I notice that your depression and sense of hopelessness is not particularly high," says Dr. Duhamel. "That's great. However, your frustration, anger, and panic are pretty high, and I'm concerned about your lack of sleep. I think you've pretty much struggled with many of these symptoms, on and off, most of your life."

"Yeah, no kidding," says Jake.

Continues Dr. Duhamel: "And, I understand how things have gotten worse since the incident with your kids rolling the car into the street. That certainly was a trigger for you and brought out those old memories of Justine becoming seriously injured."

"Yeah," says Jake. "I think that I've always been an 'on edge' type of person but that accident with Justine just set me off. And ever since then, and especially lately, it's been much worse."

"So, Jake, this way of living is kind of who you are. Not always, but a fair amount of the time you feel vigilante about making sure everything is safe, and it is associated with a lot of anxiety, frustration, and periodic panic. And when it gets worse, it gets really worse. I'm actually impressed with how much you've done with your life despite all of the strong feelings you have. I wonder if there are certain ways of thinking that you buy into that feed into your strong feelings."

Jake asks, "What do you mean, 'ways of thinking'?"

"Well, let me show you what we call 'cognitive distortions' that some people adopt, or believe, and see if you relate to any of them," answers Dr. Duhamel, who takes out a plastic tablet that has 14 cognitive distortions listed. "These are called distortions because they tend to lock a person into viewing the world in one way, which is not really the way the world is. Can you relate to any of them?"

Jake looks them over and says, "Well, yeah, I certainly catastrophize. I always think things will go bad. And I do some fortune-telling, in that I'm always predicting that something bad will happen if things don't go my way. I guess I personalize and make should statements a lot also, and I know I blame others when things don't go my way."

"That's a great start, Jake," says Dr. Duhamel. "You know, when you view the world in that way, it makes it very difficult to make changes. It's kind of like you're always sure things are going to happen in a certain way and you're always asking people to do it your way. And, when they don't, it's their fault. Does that make sense?"

"Well, yeah," says Jake. "I know I can be overwhelming with Angela and the kids." Dr. Duhamel then offers a suggestion.

"Well, how about we try a few things this next week that can begin to loosen up that tight thinking you have?"

"Sure, I'm willing to try anything," says Jake.

Dr. Duhamel talks about counteracting some of the rigid thinking that takes place with cognitive distortions and suggests that when Jake "catches" himself thinking that way, he take a few deep breaths, and consider letting go of those thoughts. He reminds him of the acronym "STOP skills" that Jake recently learned in group, which stands for ***s***top, ***t***ake a step back, ***o***bserve, and ***p***roceed mindfully. Dr. Duhamel suggests that Jake use that acronym when he sees himself wrapped up in one or more of his cognitive distortions.

"Okay, Jake. This is a great start. You are just beginning your journey into accepting who you are and making change. Remember, we talked about the dialectics—the opposites in life. And the importance of acceptance and change."

"Yes, I think I get that—I think," says Jake.

"So, you know how you have been living, but you also see that there are some steps you can begin to take to make your life a bit better," says Dr. Duhamel. "First, you're going to practice your

mindfulness, which will help you not get so caught up in your feelings. And you're going to reflect on your cognitive distortions and begin to loosen up some of that tight thinking of yours. And you'll use the STOP skills acronym to help you reflect on those cognitive distortions. I'd also like you to continue with your weekly diary, and of course, if you need some phone coaching, you can call in at the designated times. And Jake, can you do one more thing for me?"

"Sure, what is it?" asks Jake.

"This next week, if you have a situation with your wife or kids that seems out of control, write it down in detail. I'd like to do what's called a chain analysis with you. This will help us understand the triggers that make you upset and find ways of combating them in the future. That sound okay?"

"Sure," Jake answers. "I think that's a great idea."

"So one more time—practice mindful breathing, consider alternative ways of thinking that do not lock you into cognitive distortions, practice your STOP skills, do your diary, and make a note of any particularly difficult situation you have with your kids or wife. Okay?"

"Sure thing," says Jake. "That sounds great."

"Oh yeah, and one more thing before you leave today," Dr. Duhamel says. "Let me show you that app."

Jake is at the beginning of his journey with Dr. Duhamel and the DBT process. As he continues, he'll learn more skills he can practice to help monitor and manage his emotions and develop richer and more meaningful relationships in his life. As he continues to accept himself and work toward change, his life should become a bit calmer and more meaningful. But it's going to take time, acceptance, and work.

For You to Consider

1. Describe Jake's emotional dysregulation. How do you think he developed this style of being in the world, and what hope, if any, do you think he has to change it?
2. Can you identify the secondary emotion of guilt that Jake experiences due to his emotional dysregulation?
3. Does Dr. Duhamel exhibit radical acceptance? If yes, how? Is there more he can do to show radical acceptance?
4. Describe how mindful breathing can assist Jake in monitoring and managing his emotional dysregulation.
5. Describe how Dr. Duhamel practices both acceptance and change with Jake.
6. In what ways can the STOP skills acronym be useful for Jake and his family?
7. Do you believe there are additional cognitive distortions Jake did not identify with that may have him struggling?
8. What is the purpose of the chain analysis?
9. Do you believe Jake will always struggle with strong emotions?
10. Explain the purpose of phone coaching. Why do you think Jake may be reticent to use it? How can we encourage Jake to use it responsibly?
11. If Jake were to follow the treatment procedures properly, what do you think his life would look like after six months?
12. What cognitive distortions can you identify for yourself?

Summary

This chapter began by describing the development of DBT by its originator, Marsha Linehan. Struggling with self-loathing and self-harming behaviors, at age 17 Linehan was diagnosed with schizophrenia and hospitalized for 26 months. Due to the treatment she received, which included heavy psychotropic medication and shock treatment, she was determined to help others after she was discharged from the hospital. Eventually, she obtained her doctorate in psychology and became enamored with Zen Buddhism, mindfulness, and behaviorism early in her career. Her interest in mindfulness led to the belief that radical acceptance of one's condition is a prerequisite for change, and this philosophy, mixed with her interest in behaviorism, eventually resulted in the development of DBT, which she used to treat clients with suicidal and parasuicidal tendencies and diagnosed with borderline personality disorder.

The chapter next examined DBT's view of human nature. Although a behavioral approach, DBT develops from the more recent tradition of third-wave cognitive-behavioral therapy, which views personality formation as a complex interaction between behavior, biology, and context (environment) and focuses on a wide range of techniques to assist clients in accepting and changing their ways of being in the world. This approach borrows from traditional behavioral work in helping clients understand their behavioral consequences and in helping them change their behaviors; looks at how cognitions can be modified, so individuals can see the world in less rigid and more complex ways; and, instead of stressing changing symptoms, it focuses on the dialectic of acceptance and change—that is, one must be able to hold both in consciousness and move forward, accordingly. Teaching mindfulness is one method clients can use to learn acceptance. This approach also stresses the importance of building a therapeutic alliance, and we, thus, see several person-centered and existential techniques being used, such as listening, empathy, and showing radical acceptance. In addition, other humanistic techniques are used to encourage clients to examine what is important in their lives and help them understand the polarities within which they live.

After exploring DBT's view of human nature, we examined a number of key concepts. First, we described borderline personality disorder (BPD), identified several symptoms found in making such a diagnosis, and noted that DBT was designed for individuals with BPD and related disorders. We then described the biosocial theory of personality formation, which suggests that children are born with a certain temperament that can be shaped by childhood experiences. When children are biologically hardwired for emotional vulnerability and are brought up in invalidating environments, they are more likely to struggle with BPD or a related disorder. Such individuals, we noted, have emotional dysregulation. As a result, they tend to be run by their emotions, have difficulty processing information and cues from others, demonstrate impulsive behaviors, have difficulty making decisions, and have behaviors that are dictated by cognitive distortions, called "stuck thoughts." These individuals need help through therapy to function in the world.

We went on to note that dialectical philosophy is a cornerstone of DBT and that it suggests reality is composed of interrelated opposing forces and is constantly changing. This philosophy supports the notion that individuals need to understand polarities of life, such as the dialectic of acceptance of self and the need to change. We noted the three common dialectics found in individuals with BPD and related disorders: active passivity vs. apparent competence, emotional vulnerability vs. self-invalidation, and unrelenting crisis vs. inhibited grieving.

The next key concept we examined was behaviorism, and we, again, highlighted the difference between first-, second-, and third-wave cognitive-behavioral therapy. We noted that DBT relies on third-wave philosophy. Using this backdrop, we noted that in the change process DBT counselors will apply first-wave cognitive-behavioral techniques (e.g., operant conditioning, classical conditioning, and modeling), help clients complete a functional behavior analysis of their problem situations, help clients examine rigid beliefs (e.g., "I am right, and you are wrong") and suggest

more flexible ways of thinking, and use a wide range of other techniques to help clients integrate dialectical opposites and become less reactive to the world.

Highlighting Zen Buddhism and its relationship to mindfulness was the next key concept, and we unscored the notion that mindfulness helps clients see the interconnectedness of life and the polarities within which we all live. Mindfulness practice helps clients see the impact they have on self and others and helps them be more accepting of themselves, while understanding that change is a part of life. The last key concept we noted was the seven basic assumptions of DBT: people are doing the best they can; people want to improve; although people are doing the best they can, if they are suffering they need to try harder and be even more motivated to change; people may not have caused all of their own problems but will have to solve them anyway; new behavior has to be learned in all relevant contexts; all behaviors (actions, thoughts, emotions) are caused; and figuring out and changing the causes of behavior is a more effective way to change than judging and blaming (Linehan, 2015a, p. 53).

A good portion of the chapter focused on the techniques used in DBT. DBT's therapeutic process consists of a pretreatment phase of counseling followed by four modes of therapy, which occur concurrently: individual counseling, group skills training, consultation team meetings, and between-session phone coaching. Treatment typically lasts for four to five hours per week for six months to a year and employs a variety of techniques within each of the modes. A summary table (Table 1.3) is provided in the chapter that identifies the major techniques and goals of the pretreatment stage and of the four stages of individual counseling.

These four modes of DBT work hand in hand, as the client moves from a more crisis-oriented, emotionally dysregulated state marked by destructive behaviors and cognitive rigidity to an ability to moderate their emotions and think in more complex and relativistic ways. Along this path, while in group skills training, the client learns a number of specific techniques and ways of living in the world that are reinforced in individual therapy, and vice versa. Phone coaching is available for clients who need emotional support between sessions, which also offers clients an opportunity to connect with their counselor during the week and fine-tune some of their newly learned skills. Consultation team meetings occur weekly, so the treatment team can consult with one another about the treatment plan and support one another regarding their work with clients.

As the chapter neared its conclusion, we examined several social and cultural issues related to DBT. We noted that DBT is used in 30 countries and is suitable for children and adults as well as individuals from any sexual orientation, gender, race, or ethnicity as well as from most cultures. We noted that DBT may, at times, need to adapt the approach if a client is wary of Eastern philosophy techniques (e.g., mindfulness) or of Western techniques (e.g., classical behaviorism). Knowing the ethno–psychological and spiritual makeup of the client is crucial, and some adaptations of DBT to other cultures have been successful. We also talked about the importance of adapting DBT if a client is from a collectivist culture. However, we noted that the cross-cultural efficacy of DBT is still in question, and as more studies are completed, we will better be able to assess its efficacy with all clients.

Within the final part of the chapter we noted that DBT is particularly efficacious with treating suicidal ideation and behavior, self-injury, depression, anger, emotional dysregulation, and anxiety. As one might expect, it also shows particular efficacy with individuals with BPD or related disorders. DBT has been shown to be cost-effective and is often better than treatment as usual (TAU; e.g., psychotherapy with or without medication). Although a relatively recent addition to psychotherapeutic theories, DBT has quickly amassed a large body of respectable research, much of which uses randomized controlled studies (RCT). Near the end of this section we delineated a number of disorders for which at least one RCT study had been conducted and for which DBT showed promise as a treatment modality.

Key Words and Terms

acceptance of change
acceptance skills
active passivity
apparent competence
assessment
behavioral skills
behaviorism
between-session coaching
biosocial model of personality formation
biosocial theory
black and white thinking
borderline personality disorder
boundaries of the relationship
building relationships and ending destructive ones
catastrophizing
chain analysis
change skills
changing unwanted emotions
cognitive skills
commitment to change
consultation team meeting
crisis survival skills
dialectic
dialectical communication skills
dialectical philosophy
diary card
discounting positives
distracting with wise mind ACCEPTS
distress tolerance
emotional dysregulation
emotional mind reasoning
emotional regulation
emotional volatility
emotional vulnerability
first wave of cogniive behavioral therapy
14 cognitive distortions
fortune-telling
functional behavioral analysis
group skills training
half-smiling and willing hands
how skills
IMPROVE the moment
individual counseling
inhibited grieving
interpersonal effectiveness
invalidating environment
irreverent communication
labeling
making lemonade out of lemons
managing extreme emotions
mind reading
mindfulness
minimization/magnification
negative environment
obtaining objectives while maintaining relationships and self-respect
orientation and commitment
overgeneralizing
personalization
phone coaching
playing the devil's advocate
pretreatment stage of counseling
pros and cons
purpose and process
radical acceptance
reality accepting skills
reciprocal communication
reducing vulnerability to emotional mind
regret orientation
reinforcing of group skills training
role reversal
second wave of cognitive-behavioral therapy
selective information gathering
self-invalidation
self-soothing
seven basic assumptions
should statements
stages I–IV of individual therapy
STOP skills
structuring therapy
TIP skills
third wave of cognitive-behavioral therapy
turning the mind
understanding and naming emotions
unrelenting crisis
using metaphors
verbal or written agreement
walking the middle path
willingness
wise mind
what skills
Zen Buddhism

Key Names

Beck, Aaron
Edwards, Tilden
Ellis, Albert
Jager, Willigis
Linehan, Marcia
May, Gerals
May, Rollo
Millon, Theodore

CREDITS

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Fig. 14.1: Source: https://www.youtube.com/watch?v=OTG7YEWkJFI.

Acceptance and Commitment Therapy[1]

15

Learning Goals

At the conclusion of this chapter, readers will:

- have a historical understanding of ACT and learn about its originator, Steven C. Hayes
- understand ACT's view of human nature relative to it being a third-wave cognitive-behavioral approach
- be familiar with key concepts of ACT, including relational frame theory (RFT), the theoretical foundation for ACT; how human suffering is caused by the nature of language; the six processes of psychological inflexibility; and the six processes of psychological flexibility
- be able to identify a number of key techniques important to the practice of ACT, including compassion, acceptance, respect, and empathy; promoting a collaborative and egalitarian relationship; taking a history; obtaining informed consent and goal setting; psychoeducation; using analogies, metaphors, stories, paradoxes, and mindfulness; and exercises related to psychological flexibility
- be familiar with the therapeutic process of ACT
- have knowledge about social, cultural, and spiritual applications of ACT
- gain knowledge about the efficacy of ACT

This second chapter of Section V provides a brief history of acceptance and commitment therapy (ACT), including a biography of Steven C. Hayes, considered to be its founder. We then describe the view of human nature from an ACT perspective, followed by its key concepts; ACT techniques and therapeutic process; social, cultural, and spiritual issues associated with ACT; and ACT efficacy research. We conclude the chapter by illustrating this approach with Jake, a member of the Miller family.

Steven C. Hayes

Acceptance and Commitment Therapy (ACT, pronounced like the word "act") is a *third-wave cognitive-behavioral therapy* (Hayes, 2004; Hayes et al., 2012a). The *first wave of cognitive-behavioral*

1. The authors are grateful to John C. Wren, Robert R. Armbruster, and Abie Tremblay for their contributions to a previous version of this chapter in the text, *Contemporary Theories in Counseling & Psychotherapy* (Neukrug, 2021).

Edward Neukrug, John C. Wren, Robert R. Armbruster, and Abie Tremblay, "Acceptance and Commitment Therapy (ACT)," *Contemporary Theories in Counseling and Psychotherapy*, ed. Edward Neukrug, pp. 190-227. Copyright © 2019 by Cognella, Inc. Reprinted with permission.

FIGURE 15.1 Steven C. Hayes

therapy, pure behavioral therapy, such as that proposed by *B. F. Skinner* (1957), was characterized by a rejection of the unobservable constructs of psychoanalytic theory (e.g., id, ego, superego) and a focus on applying evidence-based behavioral principles to correct problematic behaviors and emotions (Hayes, 2004; Hayes et al., 2006). In the first wave, stimuli were believed to evoke behavioral responses, and change was produced by eradicating old responses and conditioning new responses.

The mechanistic and strict behavioral focus of behavioral therapy of the first wave, however, omitted consideration of cognitions, and new theories soon arose that suggested that cognitive processes and symbolic memory played a critical role in the development of behaviors (Bandura, 1977). Thus, *Aaron Beck*, *Albert Ellis*, and others began *second-wave cognitive-behavioral therapies*, which focused on how cognitions mediated behaviors, feelings, and physiological responses (Hayes, 2004; Hayes et al., 2006).

Although the popularity of these new cognitive therapies flourished (increasingly termed cognitive-behavioral because they often also incorporated behavioral change), the practice of directly changing the content of thoughts and beliefs began to be challenged (Hayes, 2004; Hayes et al., 2004a, 2006). It soon became evident that attention to simply changing out behaviors, or cognitions, did not adequately address mechanisms of change.

With questions regarding the nature of change of the first- and second-wave cognitive-behavioral approaches, *third-wave cognitive-behavioral therapies* were born and included dialectical behavior therapy (DBT; see Chapter 14; Linehan, 1993, 2020), functional analytic psychotherapy (FAP; Kohlenberg & Tsai, 1991), integrative behavioral couples therapy (IBCT; Christensen et al., 2015), mindfulness-based cognitive therapy (MBCT; Segal et al., 2013), and ACT. While remaining committed to an empirical, principle-based approach, these new therapies incorporated constructs generally considered less empirical, such as spirituality, values, and mindfulness (Hayes et al., 2004a, 2006). Rather than attempting to only focus on behaviors and/or cognitions, most third-wave therapies also attempt to change the context (Cloud, 2006).

Steven C. Hayes is credited as the founder of ACT. Currently a foundation professor at the University of Nevada, Reno, during the late 1980s Hayes was noted as one of the most influential psychologists in the world by the Institute for Scientific Information (Podina & David, 2017, p. 178). Growing up in Southern California in the 1960s, Hayes wanted to study something that would combine his interest in the humanities with his passion for science, and even though he knew little about the subject, he chose psychology. Although raised Catholic, by the time he attended Loyola Marymount University, a Jesuit university in Los Angeles, he had left the church (Hayes, 2008). While at Loyola, he was inspired by Skinner's work and by *Irving Kessler*, a recent addition to the faculty, who demonstrated the connection between behaviorist theory and clinical practice. He also took part in the counter-culture movement prominent at the time and became enamored with Eastern philosophies, particularly the writings of *D. T. Suzuki* and *Alan Watts*. After graduation, Hayes continued this interest by spending time in an Eastern religious commune run by *Swami*

Kriyananda. In 1972, Hayes married his high school sweetheart, *Angel Butcher*, three years after the birth of their daughter.

Hayes went to West Virginia University (WVU) for his doctoral training, becoming immersed in the behavior analysis work for which WVU was, and remains, renowned. Hayes next did an internship at Brown University, where he was heavily influenced by *David Barlow,* whose research focused on the treatment of anxiety disorders. Subsequently, he spent nine tumultuous years as a member of the psychology faculty of the University of North Carolina at Greensboro in 1977. The psychology department was divided between behavioral and cognitive faculty, and the conflict between the two groups was intense (Hayes, 2008). During one department meeting in 1978, as tensions rose, Hayes found himself unable to speak and thought he had a heart attack. This was his first panic attack, and they became more frequent over the next two years (Cloud, 2006). Adding to the stress during this period, he and Angel divorced (Hayes, 2004). By 1980, his anxiety made it almost impossible for him to lecture, and he avoided public spaces, such as restaurants or movie theaters, almost entirely (Cloud, 2006). In part, his attempts over the next three years to overcome his anxiety disorder, which, by now, made life unlivable, led him to the development of ACT (Hayes, 2008). Hayes realized that the standard ways of coping, such as tranquilizers or trying to process a panic attack cognitively, and thus, controlling it, only led him to focus more on the panic and made the condition worse (TEDx Talks, 2016).

Hayes, with his first doctoral student *Robert D. Zettle*, started to investigate how clinical issues (e.g., anxiety disorders) were impacted by language, verbal behavior, and rule-governed behavior (e.g., rigid thinking based on rules given to us by others; Zettle, 2001). In particular, they were attempting to apply, from a radical perspective, Beck's practice of having clients distance themselves from their thoughts and beliefs, or as Hayes stated (2016), "It's being able to look at your thoughts, not just [coming] from your thoughts" (11:48). This early therapeutic form, termed *comprehensive distancing*, went beyond Beck's concept of "distancing." With Beck, the process involved looking at one's thoughts in an effort to replace and with Hayes, individuals were encouraged to find ways to distance from their thoughts so they would hold less power. This process eventually would bloom into ACT (Hayes, 2008; Zettle, 2011).

Over the same period of time, Hayes was beginning to develop *relational frame theory* (RFT), a behavioral and contextual approach to language and cognition (Hayes et al., 2001). The first detailed account of RFT was presented at the 1985 Association for Behavior Analysis (ABA) convention (see Hayes & Brownstein, 1985). In recent years, *Dermot Barnes-Holmes*, at the National University of Ireland, has directed extensive research into RFT as a theoretical background for ACT and as an independent science (Podina & David, 2017). Today, RFT continues to inform the practice of ACT, although the link between RFT and ACT is tenuous (Barnes-Holmes et al., 2016; Blackledge & Drake, 2013).

View of Human Nature

Similar to other third-wave cognitive-behavioral therapies, ACT focuses more on the context of an individual's thoughts and emotions than the content. Whereas *first- and second-wave cognitive-behavioral approaches* (e.g., behavioral therapy, CBT) assumed that maladaptive behaviors or cognitions need to replaced, third-wave approaches suggest that "no thought, feeling or memory is inherently problematic, dysfunctional, or pathological: rather, it all depends on the context" (Harris, 2009, p. 34). ACT is a type of *functional contextual theory* because it examines the current and past biological, social, physical, and cultural context (or environment) in which *private events*, sometimes called *psychological events* (i.e., things people do, think, or feel), are formed (Fox, 2004–2022). Then, rather than replacing behaviors or cognitions, acceptance of one's psychological

events and slowly chaning one's context can, over time, make adjustments to how one lives in the world and is the key to living a more meaningful life.

ACT is informed by RFT, which is a behavioral description of how human language and cognition is developed and how individuals create webs of *relational frames* that mediate the things they do, think, and feel (their private events). Relational frames can lead to painful emotions and dysfunctional behaviors when they result in rigid thinking and experiential avoidance that prevent individuals from confronting their problems and seeking values important to their lives. However, by helping clients build *psychological flexibility*, which includes using mindfulness, acceptance, and what is called cognitive defusion (not being rigidly attached to our thoughts), individuals can change the context of their negative thoughts, feelings, and memories and lessen their impact. This contrasts greatly with theories that view thoughts, feelings, memories, and related behaviors as part of a "faulty machine" that needs to have parts replaced (Harris, 2009; see Box 15.1).

BOX 15.1 Focus of Functional Contextualists Compared to Other Psychological Theories

- **psychodynamic counselors:** Focus on changing faulty ego development
- **existential–humanistic counselors:** Focus on changing feelings and related incongruent behaviors, generally attributed to low self-esteem
- **cognitive counselor:** Focus on changing faulty, irrational, or negative beliefs
- **narrative counselors:** Focus on changing a person's problem-saturated narratives

In contrast:

- **functional contextualists:** Changing the context of thoughts, feelings, and behaviors, so their function (e.g., being painful) no longer holds the same power. (In ACT, the development of psychological flexibility can assist with changing the context.)

You can see that ACT is rooted in behaviorism, as RFT is based on how stimuli become reinforced into a web of relational frames; has Eastern influences, as it uses mindfulness, meditation, and related philosophies to develop psychological flexibility; and has some humanistic tendencies in its belief that people can move forward in life. However, it is clearly its own theory that is part of the third-wave cognitive-behavioral movement, along with DBT, mindfulness-based therapies, and other related approaches.

Key Concepts

We begin this section with an overview of RFT, a complex theory, which underlies the basis for the practice of ACT. The section then transitions to a discussion about how RFT is related to language development and how the mind can foster psychological inflexibility and human suffering. Six processes of *psychological inflexibility* we discuss include cognitive fusion, experiential avoidance, being stuck in the past or the future, attachment to a conceptualized self, lack of clarity of values, and unworkable action. The section concludes with the six processes of *psychological flexibility* to which ACT counselors help clients strive. These include defusion (watch what you're thinking), acceptance (open up), contact with the present moment (be here now), self-as-context (pure awareness), values (know what matters), and committed action (do what it takes).

Relational Frame Theory

> Relational frame theory (Hayes et al., 2001) is a comprehensive functional contextual program of basic behavioral research on human language and cognition. (Hayes et al., 2004b, p. 21)

RFT explains how what we do, think, and feel (our private events) and the language we use is related to the manner in which stimuli were reinforced and subsequently associated with one another into a matrix of *relational frames* (ways that we come to see and act in the world) that are unique for each person (Fox, 2004–2022). We cannot undo this matrix, but we can add to it and modify it.

RFT posits that as increasing numbers of stimuli become associated with each other, each of us creates a unique web of relational frames from which we view the world (Hayes et al., 2012a). For example, a child might be reinforced for a *derived stimulus relationship* between the word "cat" and the warm, furry animal the child sees (Figure 15.2, arrow 1). Thus, "cat" is equal to the warm furry animal, and because of the way the human mind works, a warm furry animal is also equal to a cat. Then, a child is taught that the word rabbit is a warm fury animal (arrow 2). So cats are warm, furry animals, and rabbits are warm, furry animals, and because of how the human mind works, a relationship is formed between a rabbit and a cat, since both are warm, furry, animals (arrow 3). In addition, a derived stimulus relationship is formed between the warm, furry animal "cat" and the word "rabbit" (arrow 4) and between the warm, furry animal "rabbit" and the word "cat" (arrow 5). Thus, cats are related to rabbits, and rabbits are related to cats. At some point, a child may be scratched by a cat (arrow 6), and when someone says the word "cat," the child will get upset (arrow 5). So "cats" and "warm furry animals" can scratch. And because cats are related to rabbits, rabbits have now been secondarily associated with getting scratched (arrow 8). And one can readily see how this can get generalized to other warm furry animals. Lo and behold, a phobia has been formed! We can also see how someone can develop a series of relational frames that results in thoughts that being at home with no animals is better than being with a with warm, furry, animals—that scratch. Here we see an *arbitrary* relationship has been formed between warm, furry animals and being scratched. It's arbitrary because it is unique to this individual's situation and not a "given" in life.

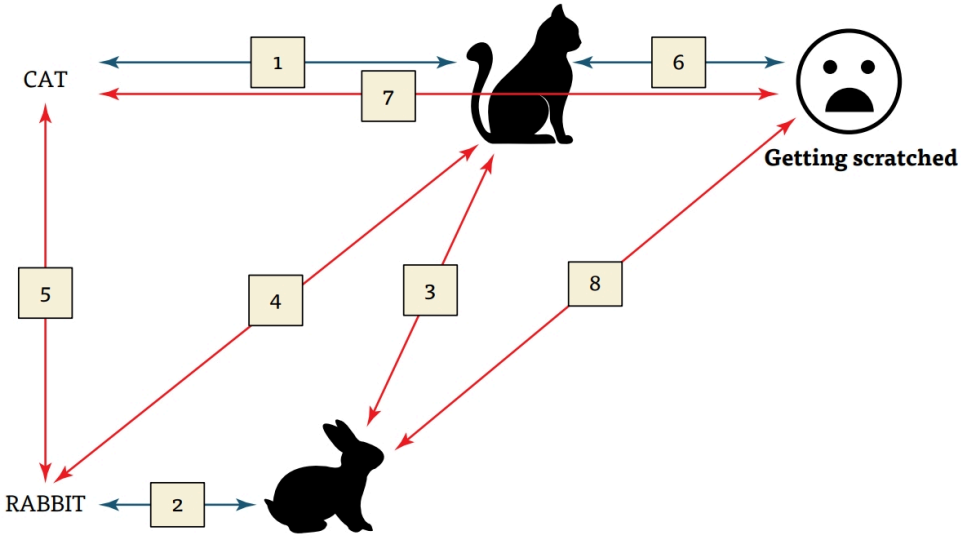


FIGURE 15.2 Relational Networks

You can see how our relational frames are the basis for a person's private events, which can be helpful as well as unhelpful (e.g., unhelpful because of the notion that all warm, furry animals scratch). When two or more stimuli become related to one another, it is called *combinatorial entailment* (they "combine"). So imagine the infinite number of relational frames humans develop, as many stimuli become associated in arbitrary ways with many other stimuli. These relational frames are "the patterns of relational responding that occur within different contexts for which each person gets reinforced" (Gross & Fox, 2009, p. 91) and are the basis for our cognition and our language development. Because it is a web of relationships, it is complicated, involved, and not easy to change. You cannot take it apart, but you can accept it as it is and create new webs of relationships that can change how the original web functioned.

Human Suffering Is Caused by the Nature Language

> ACT highlights the ways that language traps clients into attempts to wage war against their internal lives. (Dewane, 2008, para. 9)

ACT assumes that humans suffer as a result of the complexity of the relational frames they have developed and the associated language that is used, which can include *private language* or *public language* (Harris, 2006). Private language includes "thinking, imagining, daydreaming, planning, visualizing and so on" (p. 4), often called "cognition" (e.g., a person thinking, "Those warm fury animals are going to scratch me! I'm scared of them"). Public language includes "speaking, talking, miming, gesturing, writing, painting, singing, dancing, and so on" (p. 4; e.g., a person announcing, "Let's ban all warm, furry, animals!"). The word "mind" is symbolic of the different kinds of language we have developed (see Figure 15.3).

Although language can be used to help us understand one another and the world, to find solutions to major problems (e.g., invention and scientific revelations), to show empathy, and to advocate for important causes, language can also increase suffering. For instance, public language can be used to lie, bully, respond in sexist and discriminatory ways, and more. Private language can cause us to judge and feel bad about ourselves, imagine negative things from the past that cause us pain or imagine things about the future that might cause us anxiety, and develop rules about how we should live our lives that can constrict our behaviors. Thus, language can result in painful *private experiences* (e.g., emotions, memories, thoughts, sensations, and other internal experiences) and the making of poor choices. For instance, the person who has the thought while working out, "I could have a heart attack like my dad had," avoids working out in the future. Or the individual who constantly thinks their spouse should act differently becomes verbally abusive, and the relationship deteriorates. Or the person who has the mantra "life will be good when I retire" lives a depressive life and just waits for retirement. Here's where language wreaks havoc on the person. Thus, the primary reason why our mind is not our friend is because we developed the kinds of language usage that results in psychological inflexibility.

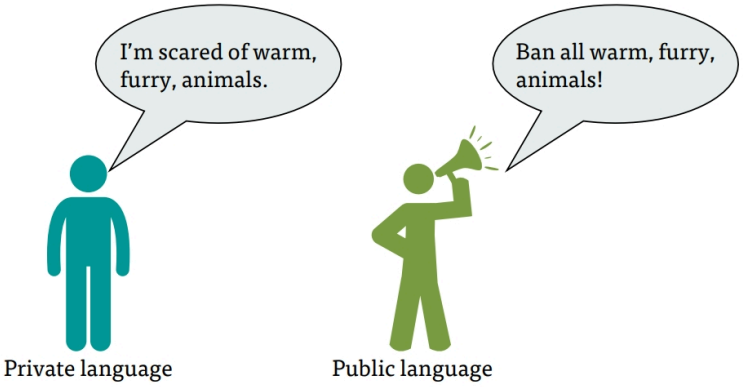


FIGURE 15.3 Private and Public Language

Psychological Inflexibility

Psychological inflexibility describes six interrelated processes that result in an inability to act in a manner consistent with one's values (Harris, 2009; Törneke et al., 2008). They are interrelated because they tend to impact one another in various ways. They include *cognitive fusion*, *experiential avoidance*, *being stuck in the past or the future*, *attachment to a conceptualized self*, *lack of clarity of values*, and unworkable action. These six processes can be contrasted with the six parallel processes of psychological flexibility, which include: *defusion* (aka cognitive defusion), *acceptance*, *contact with the present moment*, *self-as-context*, *values*, and *committed action*. Psychological flexibility will be discussed in the next section.

Psychological inflexibility that causes a mental health problem is readily reinforced due to its short-term benefits, even though it has long-term detrimental effects. For instance, a person with a social phobia is fearful of being judged and rejected in social situations and, thus, avoids such situations. Avoiding social situations does result in short-term relief, as the individual does not have to experience the anxiety or panic of being in social situations. However, this results in a life inconsistent with one's desire of wanting to be with others. The following describes the six processes of psychological inflexibility.

Cognitive Fusion

Cognitive fusion is when one becomes caught up in thoughts that cause serious distress, yet one continually thinks about such thoughts despite the fact that ruminating causes more distress. Cognitive fusion occurs when one is rigidly attached to thoughts that tend to be rule bound, judgmental, leave little room for change, and involve black and white thinking (Harris, 2009; Hayes, 2004). Often, such thoughts:

- seem like absolute truth,
- seem like they have to be followed,
- dominate one's understanding of self,
- seem like they have to be eliminated right away,
- are about the past or about the future and cause constant worry, and/or
- seem impossible to let go of even though they negatively impact one's life.

Such thinking is often fused, or related to, painful memories from major caretakers and result in disappointment, rejection, failure, abuse, and feelings of low self-worth. Such experiences result in self-statements like, "I am no good," "I can't ever succeed," "I am not worthy," "Why try; it won't work out," and so forth (Harris 2009). In ACT, clients are encouraged to recognize these thoughts and not try to stop them but not get hooked into believing them. It's kind of like the "self" is on a bus, and the riders are the individual's thoughts. Here the self can observe the thoughts but not get caught up in them. Or imagine a deck of cards, one by one being thrown at you. Now, imagine the cards are thoughts. Instead of trying to catch the cards ("thoughts"), the individual learns how to just look at them as they go by. The opposite of cognitive fusion is defusion, which will be talked about in the next section on psychological flexibility.

Experiential Avoidance

> For us humans, private events readily acquire aversive stimulus functions through relational framing, and thereby also become objects of avoidance. (Törneke, et al., 2008, p. 149)

From an evolutionary perspective, human beings have developed problem-solving mechanisms to address external problems that could threaten their survival (Harris, 2006). For instance, after discovering that bears can kill you and realizing that throwing rocks at them can only go so far, humans developed more complex strategies to avoid bears. Although avoidance strategies may work well when dealing with external threats, such as bears that stalk, they have not been so helpful when applied to symptoms, which can include difficult feelings, memories, sensations, and thoughts (Hayes et al., 1996). In fact, trying to avoid difficult feelings, memories, and thoughts actually increases difficult feelings, memories, or thoughts.

For instance, the individual who is depressed naturally wants to fight off or avoid their sad feelings. However, attempts at avoiding one's depression generally results in a person becoming more depressed, such as when a person refuses to discuss painful depressive feelings, never deals with the pain, and lives with unresolved painful feelings, or the person who purposefully avoids social contact due to a fear of being anxious around people and then becomes depressed and anxious because they have no friends or acquaintances. *Experiential avoidance* is often fueled by cognitive fusion because if one is fused or experiencing difficult thoughts they drastically want to try and avoid them. For instance, the anxious person who is avoiding interacting with others is often obsessed with thoughts like, "I'm not good enough to be around others" (thinking probably fused with early painful memories from caretakers—"You're not good enough"). Thus, this individual does not live out their values of wanting to be with people, which would enrichen their life. The opposite of experiential avoidance is acceptance of self, which will be talked about in the next section.

Being Stuck in the Past or Future

Instead of living in the present, these individuals obsess about the past or ruminate about the future. They think about how things would have been "if only ..." or worry about how things might be in the future. It is the individual who is always thinking and worrying about how past abuse impacts them now or the person who is constantly obsessing finding a partner to make their lives better in the future. The opposite of being stuck in the past or future is being able to have contact with the present moment, which will be talked about in the next section.

Attachment to a Conceptualized Self

Our conceptualized self is the self we have come to know based on our life story and often includes such things as our name, cultural background, age, gender, marital status, occupation, degrees we hold, activities we embrace, avocational activities, labels we adhere to, and so forth. We all have a conceptualized self, but when we rigidly adhere to one or more aspects of it, we become our self-description, as opposed to having a description of self. For instance, the psychiatrist who is fused with perceptions of what it is to be a psychiatrist is not able to consider alternative mechanisms of treating clients and believes they must always play the role of "psychiatrist"—even with friends and those with whom they are close. The opposite of attachment to a conceptualized self is having a flexible understanding of self within one's context, which will be talked about in the next section.

Lack of Clarity of Values

This is when one's cognitive fusion, experiential avoidance, being stuck in the past or future, or a rigid conceptualized self prevents a person from having clarity about one's values and from acting in a manner that embraces such values. For instance, the depressed individual unhappy

and unsatisfied with their current career is obsessed with thoughts of not being capable on the job (cognitive fusion), avoids finding a new job (experiential avoidance) because they are anxious about what the future might hold (being stuck in the future), and strictly adheres to the career roles they have taken on (rigid conceptualized self). The opposite of lack of clarity of values is having clarity about one's values, which we will discuss in the next section.

Unworkable Action

These are feelings, thoughts, and behaviors that are antithetical to purposeful, intentional, and mindful actions that prevent one from moving towards chosen values. They include actions that are impulsive, reactive, and automatic—not thought through. It is the abusive spouse who screams at or hits their spouse without thinking, the substance abuser who automatically takes drugs, the individual who refuses to consider finding a partner even though they are lonely, the person dissatisfied with their job who complains but does not look for other work, and so forth. The opposite of unworkable action is committed action, which will be talked about in the next section.

Because the goal of ACT is to "create a rich and meaningful life while accepting the pain that inevitably goes with it" (Harris, 2006, p. 2), one needs to learn how to disengage from psychological inflexibility and welcome a new way of living that embraces psychological flexibility.

Psychological Flexibility

The antithesis of psychological inflexibility, *psychological flexibility*, refers to the ability of an individual to live in the present moment, accept one's current state of being, and act in accordance with their chosen values (Hayes et al., 2012b). Psychological flexibility is comprised of six core interrelated dimensions or processes, which include defusion (watch what you're thinking), acceptance (open up), contact with the present moment (be here now), self-as-context (pure awareness), values (know what matters), and committed action (do what it takes); Harris, 2009; Hayes et al., 2012a, 2012b). Visually, each of these six elements of psychological flexibility can be viewed through the *hexaflex model* (see Figure 15.4). Notice how lines connect the various processes, indicating how they are interrelated, or impact one another and, together, develop psychological flexibility. Examples of how these processes are used in counseling will be given in the techniques section that follows this section. Meanwhile, let's take a look at each of these processes.

Defusion (Watch What You're Thinking)

Whereas cognitive fusion is being attached to one's thoughts, *defusion* (aka *cognitive defusion*) is letting go of one's thoughts and understanding that one is not dictated by one's thoughts. Harris (2009) notes that a defused state is one in which a thought:

- may or may not be true
- is definitely not a command you have to obey or a rule you have to follow
- is definitely not a threat to you
- is not something happening in the physical world: it is merely words or pictures inside your head
- may or may not be important—you have a choice as to how much attention you pay it
- can be allowed to come and go of its own accord without any need for you to hold on to or push it away (p. 21)

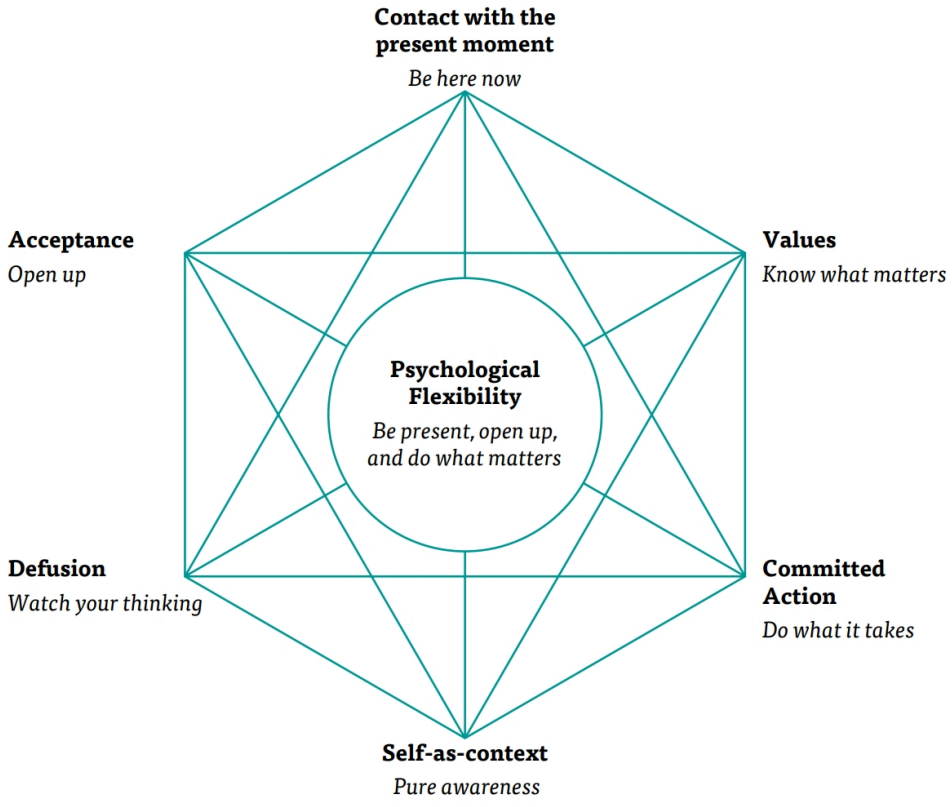


FIGURE 15.4 The Hexaflex Model

People who are cognitively defused are able to take a step back from their thoughts and watch what they are thinking, imagining, or remembering. They have the ability to not get too attached or caught up in their thoughts. This is the individual who has been an abusive spouse who has learned to take a moment to stop and think about their thoughts, use a mindfulness exercise to separate and watch their thoughts, and not react to them. This enables the person to take a new purposeful action that is loving, or at least neutral, toward their spouse.

Acceptance (Open Up)

Acceptance is allowing oneself to experience (open up to) difficult private experiences (e.g., emotions, memories, thoughts, sensations, and other internal experiences), so the individual can make powerful choices that are more congruent with one's values (Batten & Ciarrochi, 2015; Harris, 2009; Neale-McFall, 2015). For instance, a person who values being in relationships but has been hurt by them in the past is depressed and may avoid future relationships for fear of being hurt again. Acceptance would be the act of allowing oneself to experience the hurt in the moment, not participate in experiential avoidance, and choose, despite one's pain, to take actions that would result in being in a loving relationship again.

Contact With the Present Moment (Be Here Now)

Flexible attention to the present moment is the process of coming in contact with the here and now (Neale-McFall, 2015). This occurs when one experiences the moment, suspends judgment, lets go of

expectations, and gives complete, purposeful attention to one's psychological or physical world. It is the ability to move from narrow, focused attention to broad, diffuse attention and also opens up a person to moving from things that have happened in the past, or things that might happen in the future, to what is happening in the now. This can be of great value, as anxiety and worry are often a function of focusing solely on what has occurred or what will occur. For instance, the person who had been abused as a child and constantly obsesses about the abuse can use mindfulness exercises to help focus upon, and feel grounded in, the present. This lessens rumination about the past and allows the individual to think about healthy choices for the future.

Self-as-Context (Pure Awareness)

Consider this: Are you the thoughts in your head? Or are you your awareness of your thoughts in your head?

As children are raised, they develop certain narratives that becomes their "I," or the way they view themselves. For instance, they might think of themselves as bright, athletic, less than ..., better than ..., pretty, ugly, a worrier, and so forth. They view their self in relationship to the content that describes them, sometimes called *self-as-content*. This necessary simplification is a useful shorthand way to think about and describe who and what one is (Törneke, 2010); however, as we grow older, it can dominate thoughts, influence behaviors, and become a rigid way of viewing self. In contrast, *self-as-context* is the ability to detach from these narratives and the content of our thoughts, our feelings, and our experiences associated with them. It is considered by some to be a transcendent state, or meta-awareness of self, in which one defuses or separates self from one's content. This concept is similar to a state achieved during meditation (Hayes et al., 2012a). This is the individual who is a psychiatrist but not rigidly wed to this role. This person is open to alternative ways of treating individuals and does not need to maintain the role of "psychiatrist" when with friends or their partner (see Box 15.2).

BOX 15.2 Who Am I?

I (Neukrug) remember spending five days at a values clarification workshop, where I was asked not to state what I did for work, what degrees I held, or even what I had studied in school. I was suddenly devoid of my "self-as-content." This became a struggle for me, as I realized I was attached to my degrees and my profession—they defined who I was. However, slowly, through meditative, mindfulness, and related experiences, I began to get in touch with a new me—a me that no longer constantly needed to be the content of who I was (the me who was a counselor with degrees) and was able to let go of that content and be different "Mes," depending on the context in which I found myself (e.g., who I was around, what I was around, how I felt in the moment).

Values (Know What Matters)

> Life is what happens while you are busy making other plans (Lennon, 1980, min. 2:18)

In ACT, values are those activities that bring joy and meaning to a person's life, and they are reflective of a person's larger purpose (Harris, 2009, 2015). ACT counselors suggest it is important to distinguish between a *goal-focused life* and a *value-focused life*, with the former being focused on attainment of the goal and the latter being focused on the process, or journey, taken in living one's values. Here the individual gains a sense of fulfillment, purpose, and meaning, even when goals are not achieved. A goals-focused life results in disappointments, feelings of being a failure, and a sense of emptiness if goals are not reached. Although a goal-focused life brings small moments of joy and happiness when goals are obtained, happiness is fleeting, whereas a values-focused life brings enjoyment from the journey, and the attainment of a specific goal is like icing on the cake in the larger process.

Some common values of the value-focused life revolve around becoming a better parent, maintaining health, having

satisfactory family relationships, developing deeper intimacy in relationships, having satisfactory employment, developing ourselves personally, enjoying avocations, becoming involved in community and environmental issues, deepening one's spirituality or religion, and building social relationships (Harris, 2009). A wide variety of values clarification exercises can be used to help individuals determine what values are most salient, so they can make the best choices for themselves in their lives. One particular exercise is similar to the miracle question asked in solution-focused brief therapy:

> If you could wave a magic wand so that all these problematic thoughts and feelings no longer had any impact on you, what would you start doing, or do more of? What would you stop doing, or do less of? How would you behave differently toward your friends, partner, children, parents, relatives, work colleagues, and so on? How would you act different at home, at work, and at play? (Harris, 2009, p. 56)

Committed Action (Do What It Takes)

Committed action requires "taking effective action, guided by our values" (Harris, 2009, p. 11) in situations which elicit both positive and negative emotional experiences. The long-term purpose of *committed action* is for the client to determine and work toward goals that are helpful in maintaining harmony with stated values. Harris (2009) lists the steps of committed action as:

1. Choose a domain of life that is a high priority for change.
2. Choose the values to pursue in this domain.
3. Develop goals, guided by those values.
4. Take action mindfully. (p. 209)

Doing what it takes could require the counselor to teach traditional behavioral interventions, such as goal setting, skills training, exposure therapy, negotiation, time management, and assertiveness training, so the client can tolerate the emotions arising during committed action. However, it is always important to remember the focus should be on the development of a values-focused, not goals-focused, life. It is the lonely, depressed individual who has been fearful of seeking a partner for fear of being hurt again who can now accept the pain from past hurts, not ruminate about future concerns, and be willing to take deliberate and purposeful actions toward finding a new partner.

Therapeutic Techniques

There are a wide range of techniques that ACT counselors use, many of which relate to the development of psychological flexibility. Here we will examine the techniques of *compassion, acceptance, respect, and empathy*; *promoting a collaborative and egalitarian relationship*; *taking a history*; *obtaining informed consent and goal setting*; *psychoeducation*; *using analogies, metaphors, stories, paradoxes, and mindfulness*; and *exercises highlighting the six core processes of the hexaflex model*.

Compassion, Acceptance, Respect, and Empathy

Developing a *working alliance* in ACT is critical and often accomplished by the ACT counselor, using a variety of common skills that have been shown to be related to positive outcomes in counseling (Wampold, 2019; Wampold & Imel, 2015). Thus, the ACT counselor brings themself into the relationship having compassion for the client's predicament, being accepting of where the client currently

is, showing respect for the client, and developing an empathic relationship which demonstrates to the client they are being heard (Harris, 2006).

Promoting a Collaborative and Egalitarian Relationship

ACT counselors understand we all have life struggles with which we wrestle and that increased psychological flexibility can be helpful to the client just like it's been helpful to the counselor's struggles in life. Thus, counselors do not approach counseling from a perspective of an expert; instead, the counselor is *collaborative*, develops an *egalitarian relationship*, and shares tools they have used to develop increased psychological flexibility.

> I don't want you to think I've got my life completely in order. It's more as if you're climbing your mountain over there and I'm climbing my mountain over here. It's not as if I've reached the top and I'm having a rest. It's just that from where I am on my mountain, I can see obstacles on your mountain that you can't see. So I can point those out to you, and maybe show you some alternative routes around them. (Harris, 2006, p. 8)

Taking a History

Within the first couple of sessions, ACT counselors will obtain a history regarding the client's current symptoms and ways of being in the world (Harris, 2009). The work of ACT counselors will vary depending upon the counselor's personal style, however, they tend to assess for the following when taking a history:

- **the presenting complaint:** An examination of the presenting complaint, including a review of experiential avoidance activities that make the client feel worse.
- **initial values assessment:** An examination of the client's values, such as those things that bring purpose to the client's life, activities that would bring joy, ways the person would like to grow and change, meaningful relationships, and more.
- **life context/history:** A review of family and social history that includes such things as medical issues, counseling history, family and other important relationships, vocational concerns, financial history, and so forth.
- **psychological inflexibility:** Examining issues, such as constant worry about past or future, attachment to rigid rules and beliefs, marked experiential avoidance, attachment to a rigid identity, difficulty identifying thoughts and feelings, and more.
- **motivational factors:** What dreams and desires the client has and how external factors (e.g., the economy) and internal factors (e.g., rigid thinking) prevent a person from being motivated.
- **psychological flexibility and client strengths:** Areas in which the client is flexible, per the hexaflex model and positive strengths the client has (e.g., affability).

Obtaining Informed Consent and Goal Setting

Following a thorough assessment, the client is informed about the ACT process and the fact that there will be several experiential and skills exercises to participate in. The client is also informed that there could be some adverse effects of counseling, such as allowing oneself to experience one's pains and hurts. After being informed about the general process of ACT, treatment goals are developed and an agreement about the number of sessions is decided. Generally, those with

less psychological flexibility will entail a longer treatment protocol (e.g., perhaps a year in therapy (Harris, 2009). Goals are fairly straightforward; focused on managing, not changing, difficult feelings and thoughts; and focused on emphasizing new behaviors that can help a person move toward important values in their life.

Psychoeducation

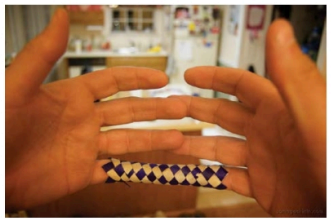
Explaining the hexaflex model to clients is an important aspect ACT, as the techniques used are directly related to the six processes found on the model (Harris, 2009). After a history has been developed and areas of psychological inflexibility determined, counselors can work with clients on those areas with which they seem to be most struggling. As the counselor addresses these areas, they can identify them for the client, explain what purpose they serve, and suggest exercises and homework they can use to become psychologically more flexible.

Using Analogies, Metaphors, Stories, Paradoxes, and Mindfulness

ACT is known for its wealth of exercises, many of which are creative and playful and most of which address the six areas of psychological flexibility. A number of these use analogies, metaphors, stories, paradoxes, and mindfulness (Ciarrochi & Bailey, 2008; Stewart et al., 2001; Törneke, 2010). All these techniques use symbolic language, which tends to be embedded in different neural channels than more traditional talk therapy and can result in significant long-term changes (Riddell, 2016). Here we define these common approaches to working with clients in ACT. Some of these techniques will also be used in the next section to demonstrate how the six core processes of psychological flexibility are developed.

Analogies

An *analogy* is a direct comparison between two or more things, which, on the surface, are often unlike one another but relay an important message to the person. For instance, to a client who is fused with the idea that their spouse must change, one might say: "Trying to get your wife to change is like trying to pull your fingers apart in the Chinese finger trap. The more you try to change her, the less likely you will see any results."



Metaphors

A *metaphor* is when you compare an abstract or symbolic thought or image to a situation in an attempt to get a person to understand a concept in new ways. For instance, a counselor might say to a person who has been struggling with anxiety, "Sounds like you're in quicksand." This may help a client become aware of how the struggles with anxiety have been dragging the client deeper into the anxiety (Ciarrochi & Bailey, 2008).

Stories

Stories allow the individual to detach themselves from the direct experience of what they are going through. Such detachment allows a client to understand their situation in a new way. For instance, a counselor who is working with a reactive client who has difficulty controlling emotions may tell the client a story about a person who could find no peace in life and decided to become a cloistered monk who chanted most of the day. After spending a few years doing this, the person came back to

his former life and found they were able to use what was learned from being cloistered to moderate their reactions to people.

Paradoxes

Since the *paradox* of ACT is that one should attempt to accept difficult private experiences, rather than avoid them, counselors often suggest that clients experience difficult emotions and thoughts, rather than evade them. For example, a client who views themself as a victim and harbors resentment toward other people with whom they work constantly tries to act nice toward them to avoid any conflict. This has the result of maintaining the symptom (i.e., feelings of constant resentment and irritability). The client's counselor suggests that the client "own their resentment" and role-play a conversation with one or two of these individuals. During the role-plays, the client permits themself to become angry and resentful and suddenly realizes that much of the resentment has to do with jealousy felt toward these people for what they had accomplished, not a function of how they were treating the client.

Mindfulness

Although not meditation, *mindfulness* is based on the contemplative traditions (e.g., Buddhism) and is a here-and-now practice that allows a person to experience negative emotions without being dominated by them, detach oneself from one's thoughts, and let go of rigid adherence to dogmatic beliefs. In other words, accept self, observe self, and move toward cognitive defusion (Hayes et al., 2012a; Kabat-Zinn, 2003; Ong et al., 2012). For those who have difficulty with the word mindfulness, alternative ways of introducing a mindfulness exercise can be used, such as, "Let's do an exercise to help you accept and understand some of the negative feelings you experience." A typical mindfulness exercise might start out in the following manner:

> Sit in a comfortable seat.
>
> Close your eyes and take some deep breaths, listening to your breath.
>
> Breathe in, then let it go.
>
> Focus on your breath, and become one with it.
>
> As you increasingly feel relaxed, watch your thoughts as they go.
>
> Remember that they are only thoughts, and you are simply observing them.

Exercises Highlighting the Six Core Processes of the Hexaflex Model

The following provides one short exercise for each of the six processes that go into the development of psychological flexibility. ACT has dozens of exercises one can use in developing defusion, acceptance, contact with the present moment, self-as-context, values, and committed action. Although each exercise may highlight one of the six processes, since the processes are interrelated, each exercise may impact other processes as well. As you read about these exercises, consider whether any of them are a type of analogy, metaphor, story, paradox, or mindful exercise.

Defusion Exercise

The purpose of a *defusion exercise* is to help clients recognize their thoughts and learn how to detach from them. Such exercises help clients understand that thoughts need not be an unconscious or automatic process but something one can notice, watch, and/or act upon. Defusion exercises can be traced back to 1916 when English psychologist *Edward Titchener* developed the Milk, Milk, Milk exercise (Snyder et al., 2011). After saying the word "milk" for about 45 seconds, Titchener realized that the word became a sound and lost its cognitive association with the physical experience of drinking a cool, white, creamy-tasting liquid. The following exercise can help a person move from a cognitively fused to cognitively defused state:

> Counselor: I know you sometimes have thoughts that are critical and demeaning of your spouse and these thoughts are followed by verbally abusive language. Close your eyes and imagine those thoughts are on a train, and you are on a station platform, watching the train and thoughts go by. Can you see those thoughts? As you watch them, realize those thoughts are separate from you—are something that does not dictate who you are and what you will do.

Exercises like the one above can be practiced in the office and at home. And when the client begins to have similar thoughts when their spouse is present, the client can practice the exercise in an effort to detach self from the thoughts and lessen the possibility of a verbally abusive reaction to their spouse.

Acceptance Exercise

If you remember, acceptance is about being at peace and accepting one's thoughts, feelings, memories, and experiences in the moment. However, it is not about resignation or giving up. Paradoxically, it is often the first step toward change. Box 15.3 shows a mindfulness exercises that helps a client accept his or her pain and consider movement toward a new life space.

BOX 15.3 Mindfulness Exercise Found on Acceptance

Counselor: Close your eyes, and let yourself sit comfortably in the chair. Listen to everything you can hear, everything you can smell, and watch your thoughts go by. Now, let yourself feel all of what you can feel. Breathe in deeply, and allow yourself to experience all of your feelings. Don't try to push them away—experience them. As the feelings arise, observe them, and know they are an important message to yourself. Think about what the feeling is telling you and let yourself experience your feelings and what those feelings might mean. As you allow yourself to experience the feelings, remember that these feelings are an important message to you in your life. Now, in your mind's eye, write down those feelings on a pad of paper. Those feelings can be used at a later point to help you make some choices about what you want to do with your life. Now, slowly relax, and think about a pleasant space in your life. Take in some deep breaths, and when you feel ready, open your eyes. (The client might then be given a pad to actually write down those feelings.)

A second example of an *acceptance exercise* shows a client who had a pet cat named Puddy that passed away a year ago and learns how to accept the pain associated with its death. The client has been avoiding feelings of grief (experiential avoidance). In this example, the counselor hears the client quickly mention Puddy but then change the subject:

Counselor: When you just mentioned Puddy, I think I saw grief in your body for a moment. Where did you notice it?

Client: In my throat and behind my eyes. I just don't want to feel all those feelings when I think about her.

Counselor: It feels like the feelings are the problem and not the solution.

Client: They are so intense. Like they will last forever and never go away. I'm afraid to open the flood gates.

Counselor: Our feelings feel real and permanent, but they are temporary and will ebb and flow within us; we can just observe them when they occur.

Client: [sits quietly, then becomes tearful and cries]

Counselor: [gives space for client to feel these feelings]

Counselor: As you experience your feelings, what do you notice in this moment? Where do you feel it in this moment? What name would you give this sensation?

Acceptance of the grief allows the individual to examine the situation, and take appropriate action, if wanted, so the client can move on with her life. Appropriate action will vary based on one's values.

Contact With the Present Moment Exercise

Contact with the present moment has to do with learning how to focus on the moment, not rigidly focusing on one's past or future, and learning how to zoom in and zoom out from a narrow to a broad focus. It can be particularly helpful in stopping a client from be distracted by upsetting thoughts. The following mindfulness exercise is an example of a counselor who is working with a very distraught client due to concern that the client's partner is going to leave the relationship. The client's mind is filled with thoughts of what can or may happen, and the client's distress is palpable. The exercise is intended to help distract the client from their thoughts and be in the moment with their body. It helps the client to stop thinking about the past or future and focus on the present.

Counselor: ... Your mind's pulling you all over the place. You're being tossed around in a storm of thoughts and feelings, and while that's going on you can't think effectively or act effectively. There's one thing you need to do before anything else: You need to drop an anchor.

Client: What do you mean?

Counselor: Okay. Push your feet hard into the floor. Feel the ground beneath you. Now, sit up in your chair, and notice how you're sitting. And look around the room and notice what you can see. Notice what you can hear. Notice what you're doing right now—notice that you and I are in this room, talking to each other. Now, take a few deep breaths, and see if you can breathe down into your feet. And keep them firmly pressed into the floor. And notice how your mind keeps trying to pull you somewhere

> else, and see if you can stay present. Notice the room around you. Notice what we're doing here, right now. (Harris, 2009, p. 167)

Self-As-Context Exercise

Instead of responding to expected ways of acting based on how we define ourselves, ACT counselors help clients find to respond to situations that do not result in excessive negative feelings. Following is a story that could be shared with clients who are rigidly attached to certain life roles, and with them, expected ways of responding: In the story that follows, look at how the farmer does not get caught up in the content of his life (a rigid identity as a farmer and a father and ways he "should" respond as a result of this identity). Instead, he finds ways of responding that do not result in excessive, unnecessary, worry about things that might or might not occur.

> While working on his farm, a farmer noticed that his old horse was sick. Rather than keeping him, he let the horse go free into the mountains. His neighbors came by and said, "We're so sorry that your horse is gone, you must be very worried that you don't have your horse to help you reap the crops. It will likely be devastating to your ability to make money The farmer responded, "Perhaps."
>
> A few days later, the horse came back, well again, and brought with him a number of healthy young horses. His neighbors again came by and told him what good fortune he had. His reply was, "Perhaps."
>
> The next day the farmer asked his son to train the new horses, and while doing this, a horse threw him, and the son had a very serious broken leg, which resulted in difficulty working. The villagers again bemoaned the farmer's misfortunate, but the farmer again replied, "Perhaps."
>
> A few months later war broke out, but due to his son's difficulty walking, he was deferred from the draft. The villagers told the farmer he and his son must be relieved, at which point the farmer said, "Perhaps."
>
> After the war, the villagers told the farmer he must be concerned that his son could not work as hard as the other young men, due to his difficulty walking. The famer responded, "Perhaps."
>
> As the men returned from war, many of them had mental health issues and PTSD. The villagers told the farmer that he must be happy that his son was not inflicted with these concerns and, despite his disability, could still work. The farmer responded," Perhaps."

Values Exercise

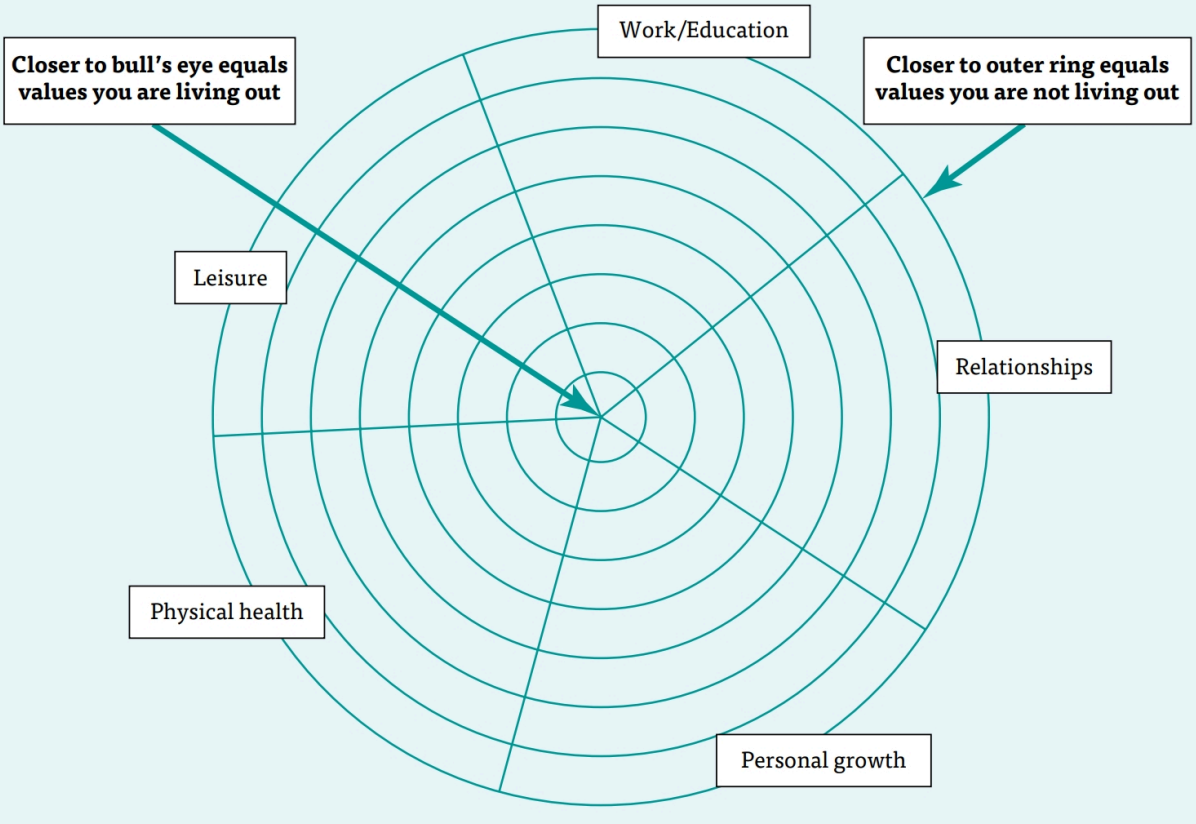
Learning what one cherishes and those qualities that give meaning to a person's life is critical if a person is to move toward living a life that best matches their *values*. However, values should not be rule based; once they become something we have to seek, they become burdensome and lose their meaning. The bull's eye in Box 15.4, adapted from Dahl and Lundgren (2006), helps people examine how they are living their lives and if they are living out values that are important to them.

BOX 15.4 Bull's Eye Values Exercise

Relative to each of the following five domains, write a short statement regarding the type of person you would like to be and how you might develop yourself as you live out your life.

- work/education (career, education, place of employment).
- relationships (partner, children, friends, co-workers, relatives).
- personal growth (counseling, spirituality, religion, creativity).
- physical health (exercise, diet, mind–body exercises, addressing disease).
- leisure (avocations, recreation, relaxation, play).

In the following bull's eye, put an X in each area to reflect where you are today, with the bull-seye representing you fully living out your values, and the outer circle representing extreme incongruence between how you're living and the values you want to embrace.



Committed Action Exercise

Identifying important values is the first step toward committing oneself toward living those values. Using Box 15.4, here is an exercise that moves one toward living one's values:

1. Identify one or two of the five domains in which one would like to take action.
2. Identify specific values to live out more fully within the chosen domain(s).
3. Develop goals for living out those values.

4. Develop strategies to use in reaching those goals.
5. Take action mindfully.
6. Use SMART goals when committing oneself to action:
   a. **specific:** Identify specific actions to take, such as when and where to take them and what exactly will be occurring.
   b. **meaningful:** Make sure goals are guided by the individual's values, are meaningful to the person, and are not fulfilling someone else's desires.
   c. **adaptive:** Ensure goals will improve the individual's life in meaningful ways, can help move the person in the direction they want to go in, and can be modified if needed.
   d. **realistic:** Make sure goals are doable, the individual has the skills to achieve them, and the amount of time needed to achieve goals are considered.
   e. **time-framed:** Set dates and times, if possible, to work on achieving goals.

The Counseling Process

The basic therapeutic process of ACT is to work through the six core processes of the hexaflex model, which allows the client to develop greater psychological flexibility and includes establishing goals toward committed action based on chosen values. The following eight steps describe a general direction of therapy, although movement back and forward between steps can easily be done, based on the client's needs in the moment.

1. **building the working alliance:** Initially, the counselor develops a working alliance with the client by demonstrating compassion, acceptance, respect, and empathy.
2. **developing a collaborative and egalitarian relationship:** Although the counselor has some specific skills to guide the client along their path toward great psychological flexibility, they do not have an air of being the "expert." Instead, the counselor develops a collaborative and egalitarian relationship with the client, suggesting certain techniques but being willing to back off if the client seems unready or opposed to any specific technique.
3. **taking a history:** Early in the relationship, the counselor takes a history from the client to help understand their current level of psychological flexibility including important values. This includes gathering information about the presenting complaint, doing a values assessment, conducting a life context/history, examining psychological inflexibility, identifying motivational factors, and examining client psychological flexibility and strengths.
4. **obtaining informed consent and setting broad goals:** Here the counselor obtains informed consent and sets broad goals based on the history that was taken. Goals are straightforward and focused on managing, not changing, difficult feelings and thoughts. They also begin to emphasize new behaviors that can help a person move toward identified values.
5. **psychoeducation regarding psychological flexibility:** At this point, the counselor explains the hexaflex model to the client and, in conjunction with the client, identifies areas to address and homework that can be worked upon.
6. **implementing exercises to develop psychological flexibility:** Here exercises that address acceptance, defusion, being in the moment, and self-as-context can be implemented, so the client can begin to develop psychological flexibility.

7. **clarifying values and embracing a value-focused life:** Concurrently, or soon after implementing exercises to develop psychological flexibility, the client can increasingly clarify important values to embrace and work on committed action toward living a value-focused, not goals-focused, life and maintain psychological flexibility.
8. **living a value-focused life:** As clients increasingly gain increased psychological flexibility, they are better able to live in the world without being haunted by private experiences that cause distress. They are also better able to accept their life circumstances, while making moves toward developing values in sync with their identities. And they are more adept at living in the world without the aid of counseling.

Social, Cultural, and Spiritual Issues

ACT can be suitable for culturally diverse clients, in particular for those who experience marginalizing contexts that influence their behaviors, feelings, and thoughts in harmful ways. In ACT, there is primary attention to present-moment behaviors, feelings, and thoughts clients are experiencing and how they are influenced by the contexts of their live (Bennett & Oliver, 2019). As such, behaviors are inseparable from context (Hayes et al., 2013), and thus, they must be judged within the context in which they occur. As culturally responsive counselors view behaviors as functions of context, they can help clients to understand the reasons behind their behaviors, introduce more adaptive coping, and collaborate with clients to move toward more culturally valued living (Bennett & Oliver, 2019).

As a context-based theory, ACT allows clients to freely choose their own values, which are derived from the cultural habits and ways of thinking that are most important in the client's life. This client-chosen context is, therefore, the aspect of ACT that can enable it to succeed in diverse cultures. As Hayes et al. (2012a) note, "Values work done well is inherently culturally adapted since the client sets the agenda and is the final expert" (p. 325).

ACT can challenge counselors to grow in their own psychological flexibility when the client's values differ vastly from those of the counselor. In these cases, counselors need to adapt their skills and techniques to make them cross-culturally appropriate (e.g., use culturally relevant metaphors and mindfulness techniques). Because counselors themselves are practicing acceptance, defusion, being present, and understanding differing values, they can more effectively work with distressing clients who are different from them (Hayes et al., 2012a).

While ACT has been used cross-culturally, its applicability with different cultures has rarely been examined. One exception is a study by Woidneck et al. (2012), who conducted a literature search for controlled trials of ACT that reported race or ethnicity of the subjects. Unfortunately, they found that the cultural composition of the subjects was reported in only a small proportion of the studies. Of those that did report cultural composition, ACT was found to be effective, but there was no analysis of differential effects of race or ethnicity on outcomes. Thus, ACT research should include more culturally diverse samples as well as directly examine whether cultural differences in ACT applicability are evident.

There is strong correspondence between ACT and the central tenets of Buddhism, and it has demonstrated good results when used in a Buddhist Cambodian community in Toronto (Fung, 2014). However, clients who reject Eastern philosophies, such as mindfulness, may have difficulty adopting some of the principles of ACT. This is why it is sometimes important to describe techniques in ways that sit comfortably with clients. Instead of using the word "mindfulness," some might be more comfortable with, "Here's a focusing exercise" or, "Here's a breathing exercise you might find helpful."

Efficacy of ACT

Despite being a relatively recent addition to the catalog of psychotherapeutic methods, ACT has been extensively evaluated in a substantial number of controlled studies, including numerous meta-analyses (e.g., A-Tjak et al., 2015; Bluet et al., 2014; Gloster et al., 2020; Hacker et al., 2016; Krafft et al., 2018; Öst, 2014; Powers et al., 2009; Ruiz, 2012). ACT has been found to be more effective than waitlist or treatment as usual (TAU) for depression and anxiety (Coto-Lesmes et al., 2020; Twohig & Levin, 2017), addiction (Luoma et al., 2012), chronic pain (Cosio & Schafer, 2015), obsessive–compulsive disorder (Bluett et al., 2014; Twohig et al., 2010), panic disorder (Meuret et al., 2012), trichotillomania (Woods et al., 2006), symptom reduction in borderline personality disorder (Morton et al., 2012), psychosis (Bach et al., 2012; Gaudiano & Herbert, 2006), and a transdiagnostic psychiatric inpatient population (Pinto et al., 2017). ACT has also shown effectiveness in improving the mental health of patients with medical conditions, including cancer (Hulbert-et al., 2015; Rost et al., 2012), epilepsy (Lundgren et al., 2006), and tinnitus (Hesser et al., 2012).

In addition to traditional individual and group methods of treatment, ACT has demonstrated effectiveness in abbreviated format (e.g., Bach et al., 2012; Ivanova et al., 2015; Kohtala et al., 2017), through internet-based delivery (Fiorillo et al., 2017; Hesser et al., 2012; Lappalainen et al., 2014), delivered within a workshop (Stewart et al., 2016), and through bibliotherapy (Jeffcoat & Hayes, 2012; Muto et al., 2011). Furthermore, ACT has been increasingly demonstrated as effective within school settings with teachers, school counselors, and students (see Beck et al., 2021).

Although meta-analyses have generally shown a significant improvement in outcomes with ACT when compared to waitlist, psychological placebo, or TAU, when compared to other therapies, the differences are negligible (A-Tjak et al., 2015; Bluett et al., 2014; Hacker et al., 2016; Öst, 2014; Powers et al., 2009). However, Krafft et al. (2018) found improved outcomes with ACT compared to educational interventions in reducing stigma towards mental illness. Ruiz (2012) also found superior results with ACT compared to CBT and that the improvements tend to be directly related to the theoretical processes found in ACT (e.g., more cognitive defusion and less experiential avoidance), while CBT did not show improvement based on its theoretical processes (e.g., reduction in automatic thoughts).

The Millers

The following shows Jake working with an ACT counselor. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Jake's Encounter With an Acceptance and Commitment Counselor

As Jake pulled into the parking lot of Waterside Psychotherapy, he began wondering whether making an appointment to see yet another counselor was wise or not. He had seen a couple of counselors over the last year, or so and had some temporary relief from his anxiety; however, he still suffered from intense periods of anxiety related to his family and their safety. Because he was concerned about traffic, Jake arrived 45 minutes early for his appointment but did not want to sit in the waiting room that long. As he waited in his car, he sized up the building. Right off, it was obvious that it used to be someone's home because it was located on the main road into a residential neighborhood and had what appeared to be homes on either side of it. He began to wonder what type of counselor would work in a repurposed house, which only intensified his debate about the wisdom of seeing yet another counselor.

After what seemed like hours, Jake finally climbed out of his car and entered the building. The reception area was on the small side, neatly decorated with a couple cushioned couches, some armchairs and one of those decorative indoor waterfalls. After completing the initial paperwork, Jake tried to settle in to wait for his counselor, Mildred Jones, to appear, but he had a difficult time sitting still. After what seemed like another hour, a diminutive older lady entered the waiting room, came up to him, and said, "Mr. Miller, my name is Ms. Mildred Jones, please feel free to call me Mildred, or Ms. Jones, whatever you feel comfortable with." Now, he really wasn't sure whether this had been a good idea; he wondered how this tiny, kind-looking older lady could possibly relate to what he was going through.

As Jake settled into another cushioned couch inside of Mildred's office, he took in the rest of the office. It was small, with a recliner in one corner, the couch against one wall, Mildred's cluttered desk in another corner near the only window in the room, and a large overstuffed bookcase opposite the couch. As Mildred spun her desk chair around to face Jake, she asked, "What brings you in today, Jake?"

Jake's response was almost robotic, as he suddenly couldn't help reciting everything he had been through. "Well, I'm just anxious and angry all of the time lately. It all started about a year ago when Luke, my son, and Celia, my daughter, were playing in my car and it accidentally rolled into the street. You see, I had a similar incident with my sister, Justine, when I was about my son's age and it resulted in her having serious cognitive impairment. Well, it's kind of like I'm stressed and angry all the time now. It's affecting everything I do. I am constantly on edge, always worried about making sure my kids are safe, having flashbacks about the accident with my sister, and not getting along with my wife, Angela. I'm up half the night worrying about things and making sure the doors are locked and the kids are safe at sleep. I even think it's impacted my performance at work. I've taken some Xanax and seen a couple of counselors, but it hasn't seemed to help much. Honestly, I think if only the kids would listen to me more and Angela would homeschool the kids, everything would be alright." Jake continued to talk, sometimes almost rambling, as Mildred listened, showed compassion and respect, and was empathic.

After Jake spoke for close to 30 minutes, Mildred took in deep breath, a breath that was almost reassuring to Jake—kind of like she was encouraging Jake to "slow down." Jake settled in his chair, and Mildred looked at him, and said, "You know Jake, this is a pretty complicated and involved story you're telling me, and I'd like to understand it fully. I hope that we can jointly work on solving some of this so you and your family can feel better. To help us both understand exactly what's going on, what about I get some information from you. Does that seem okay with you?"

Jake was already feeling comfortable with Mildred, despite his early doubts, and said, "Sure."

At this point Mildred obtained a lot of information, so she could understand the breadth and depth of Jake's situation. It included such things as the full nature of the presenting problem, values that are important in Jake's life, when and how symptoms arise, how motivated Jake seemed to work in therapy, and questions that sought to understand Jake's strengths and his level of psychological flexibility.

At the end of the session, Mildred looked at Jake and said: "You know, here's my take on your situation. First, I hear how much you love your wife and children, and how important it is for you to have a loving family that communicates well with one another. I can see how your history has brought you to the point that it is very difficult for you to do anything but what you are currently doing to make the situation better. This includes becoming very anxious and upset when your children and your wife don't listen to you about safety issues. It seems to me you are very motivated to do something in therapy, but you are just a bit lost about what to do. I think you are pretty wed to trying to take control of your anxiety and trying to enforce certain behaviors on your family. However, I'm hoping that after we talk for a while, you'll see that what you're doing is not working."

Jake listened to Mildred with intensity, thinking that she was right on target with everything she was saying. Mildred, then, looked at him and said, "You know, our session today is about over, but I think I have some ideas about how I might be able to work with you. How about we talk about some of these things next week. But perhaps, between this week and next week, if you feel comfortable, you can try something for me. You know the old saying 'a rolling stone gathers no moss'? I think you're kind of a rolling stone right now, rolling over everything in your life. I'm wondering if you can slow down a bit and instead of reacting as strongly as you are, make a few notes about your reactions when you feel strongly. So when you're about to have a strong reaction to the kids or to Angela, make some notes about your thoughts, rather than just reacting to your thoughts, kind of like you're observing yourself. Do you think you can do this?" Jake thought about it for a moment and agreed that he could do that. "Okay, it's a deal. Do that for a week, and the next time we meet we will talk about how that went; and then I'm going to introduce some other ideas I have for you."

A week later, Jake came back to see Mildred. She warmly invited him into her office, and asked, "How'd things go last week?"

"You know," Jake replied, "I think a little better. Believe it or not, thinking about what's going on and writing down my thoughts seemed to reduce some of my anxiety and frustration a tiny bit."

"That's great, and it leads into what I want to talk about with you. You see, I practice what is called acceptance and commitment therapy, or ACT. With ACT, we believe that people often get caught up in a certain way of thinking, talking, and responding that is just not so helpful for them. We believe it's kind of a style people develop over years of living a certain way. Sometimes, it's important for a person to take a step back and begin to practice some new ways of responding—or even new ways of not responding. And perhaps most importantly, I hope these new ways will help you gain what you really want—a loving family that can communicate well with one another. But before we move any further, does this make sense to you?"

Jake said that it did make sense to him, and Mildred continued, "You're an engineer, and I would guess you like to understand models or theories of how things work, so I'm going to show you something called the hexaflex model and explain how we use this in therapy." Mildred explained the model and, after she was done, asked, "What do you think?"

"Well," said Jake, "It's a little bit out there but also interesting. I think I'm willing to try some of it."

Mildred replied, "You know, you already did when I asked to observe your thoughts. That was a type of cognitive defusion. And if I must say, I think it did help a bit. I have a bunch of other things we can do—around acceptance, living in the present, how you identify who you are, and reaching your goals based on your values that you already identified as important to you. What do you think?"

Jake said, "Let's go for it." At that point Mildred obtained informed consent about the process of therapy, and the real work began.

Over the next few months, Jake worked on addressing his anxiety, frustration, and anger in a number of ways. He became more accepting of his anxiety, frustration, and anger. He lived more in the present (thought less about the situation with Justine and worried less about the future). He began to observe his thoughts when he would begin to become frustrated, which allowed him to be less reactive in his life, and he learned how his role as *father* and *engineer* sometimes locked him into feeling as if he had to respond in a controlling, all-knowing way. As he became more accepting of himself, less reactive, and less caught up in acting in a role, things began to settle down in his home, and many of his symptoms lessened. Soon, Mildred encouraged Jake to be a bit more playful with the kids and romantic with Angela, which Jake quickly embraced, since this was what he had wanted all along.

The work took time, and Jake was not always perfect in the way that he responded. But, clearly, over time he became a better father; a more loving husband; a more focused engineer, who enjoyed his work more; and a more hopeful human being.

For You to Consider

1. During the first session Mildred spent a fair amount of time gathering information from Jake. How does this inform ACT therapy? Would you feel comfortable doing an intake such as this?
2. How does Mildred show she is collaborative and wants to build a relationship with Jake?
3. How did Mildred use psychoeducation with Jake, and what purpose did it serve?
4. Can you explain how experiential avoidance has actually made Jake's symptoms worse?
5. Early on, Mildred uses the metaphor, "A rolling stone gathers no moss," to address Jake's psychological inflexibility. How comfortable would you be in using metaphors, analogies, and similar techniques? Do you think that using a metaphor was helpful?
6. What signs of cognitive fusion can you identify that apply to Jake?
7. What signs of "self-as-content" can you identify that apply to Jake?
8. A large part of what Jake will be doing is accepting himself and the anxiety and frustration he feels. How can this help Jake move to a new way of being that is more in line with his values?
9. What other techniques do you think could be employed with Jake that are in line with the ACT process of therapy?
10. What do you think is Jake's prognosis?
11. How effective do you think ACT would be with Jake's children? How about with Angela?
12. Can you identify aspects of your life in which you exhibit psychological inflexibility related to cognitive fusion, experiential avoidance, being stuck in the past or the future, attachment to a conceptualized self, lack of clarity of values, or unworkable action? Is there anything you can do to move toward more psychological flexibility?

Summary

ACT is considered a third-wave cognitive-behavioral therapy that rejects the mechanistic approach of first-wave behaviorism and second-wave cognitive-behavioral approaches. Whereas first and second wave approaches assume the client has adopted maladaptive behaviors and/or thoughts that need to be replaced, third-wave approaches suggest that thoughts, feelings, and memories are not inherently problematic and that context defines how they are experienced. This new approach incorporates several Eastern approaches, like spirituality and mindfulness, in helping an individual accept who they are and change the context of their experiences.

ACT was developed by Steven C. Hayes, who was inspired by B. F. Skinner and influenced by Irving Kessler, both of whom modeled how behaviorism could be incorporated into clinical practice. He was also influenced by individuals who were involved in the counter-culture movement and practiced Eastern philosophies, such as D. T. Suzuki, Alan Watts, and Swami Kriyananda. After experiencing panic attacks, Hayes realized that trying to control the attacks cognitively resulted in him focusing on them more and made the condition worse. Thus, he and his doctoral student Rober D. Zettle began to examine how language, verbal behavior, and rule-governed behavior impacts clinical issues. In particular, he began to look at how one can distance oneself from one's thoughts and beliefs. Slowly, Hayes began to develop relational frame theory (RFT), which took a behavioral and contextual approach to understanding language and cognition and the place

that relational frames have in preventing people from developing what he called psychological flexibility and symptom relief.

RFT suggests that private events, sometimes called psychological events (the unique things people do, think, or feel), are developed through derived stimulus relationships. As increasing numbers of stimuli become associated with each other, through a process called combinatorial entailment, RFT hypothesizes that individuals create unique webs of relational frames from which they experience the world.

Unique relational frames are the basis for each person's private language, which includes how one thinks, daydreams, and visualizes (collectively called cognition), as well as one's public language, which includes speaking talking, writing, miming, and so forth. Since language is based on unique relational frames, which are reinforced in arbitrary ways, language can be helpful or harmful. For instance, private language can help us understand others and the world, and public language can be used to show empathy and advocate for important causes. However, private and public language can also cause pain, such as when public language is used to lie, bully, or respond in sexist and discriminatory ways and when private language is used to judge ourselves, imagine negative things from the past, think about things in the future that might cause anxiety, or develop rules about how we should live our lives that constrict behaviors. Because language can be harmful, our mind is not always our friend, and we sometimes develop language usage that results in psychological inflexibility, which was described as six processes: cognitive fusion, experiential avoidance, being stuck in the past or the future, attachment to a conceptualized self, lack of clarity of values, and unworkable action.

It was noted that one of the main purposes of ACT was to develop psychological flexibility, as symbolized by the hexaflex model, which includes defusion (watch what you're thinking), acceptance (open up), contact with the present moment (be here now), self-as-context (pure awareness), values (know what matters), and committed action (do what it takes). Psychological flexibility helps individuals learn how to accept and be present with their painful thoughts, feelings, and memories; choose a valued direction in life, and take action, so they can live a more meaningful and less symptomatic life.

ACT uses a number of techniques to develop psychological flexibility and work toward committed action. Some of them include compassion, acceptance, respect, and empathy, which are all important to building a working alliance; the importance of promoting a collaborative and egalitarian relationship; taking a history; obtaining informed consent and goal setting; psychoeducation; using analogies, metaphors, stories, paradoxes, and mindfulness; and any of a variety of exercises highlighting the six core processes of the hexaflex mode.

The therapeutic process of ACT can be seen through eight steps, which are (a) building the working alliance, (b) developing a collaborative and egalitarian relationship, (c) taking a history, (d) obtaining informed consent and setting broad goals, (e) psychoeducation regarding the hexaflex model, (f) implementing exercises to develop psychological flexibility, (g) clarifying values and embracing a value-focused life, and (h) living a value focused life.

Since ACT allows clients to freely choose their own values, which are derived from the cultural habits and ways of thinking that are most important in the client's life, ACT can be used with diverse cultures. ACT can be helpful to culturally diverse clients, as they can examine the context of their experience and develop more adaptive coping mechanism by changing their context. They can also learn how to be more psychologically flexible within the context in which they live. However, sometimes ACT counselors will need to adapt their skills and techniques, so the client feels comfortable with letting go of psychological inflexibility or with some of the Eastern philosophy used within ACT. For instance, it was suggested that some might feel uncomfortable with the word "mindfulness" and that other terms can be used, such as, "Here's a breathing exercise for you." Finally, although adaptable to different cultures, little research has been completed on ACT with culturally diverse clients.

Despite its relatively young age, ACT has shown efficacy treating a wide range of conditions. It has also shown efficacy in both individual and group formats, in abbreviated form, through internet-based delivery, and through bibliotherapy. Although meta-analyses have shown a significant improvement in outcomes when compared to waitlist, psychological placebo, or treatment as usual (TAU), when compared to an active control condition, such as cognitive-behavioral therapy (CBT), the results become less clear.

Key Words and Terms

acceptance (open up)
acceptance exercises
arbitrary
attachment to a conceptualized self
being stuck in the past or the future
cognitive defusion
cognitive fusion
combinatorial entailment
committed action (do what it takes)
committed action exercises
compassion
comprehensive distancing
contact with the present moment (be here now)
contact with the present moment exercises
defusion (watch what you're thinking)
defusion exercises
dialectical behavior therapy
derived stimulus relationship
empathy
experiential avoidance
first wave of cognitive-behavioral therapies
functional contextual theory
goal-focused life
hexaflex model
lack of clarity of values
mindfulness-based therapies
obtaining informed consent and goal setting
private events
private experiences
private language
promoting a collaborative and egalitarian relationship
psychoeducation
psychological events
psychological flexibility
psychological inflexibility
public language
relational frame theory (RFT)
relational frames
respect
second wave of cognitive-behavioral therapies
self-as-content
self-as-context (pure awareness)
self-as-context exercises
six core processes of the hexaflex model
taking a history
third wave of cognitive-behavioral therapies
unworkable action
using analogies, metaphors, stories, paradoxes, and mindfulness
value-focused life
values (know what matters)
values exercises
working alliance

Key Names

Barlow, D.
Barnes-Holmes, Dermot
Beck, Aaron
Butcher, Angel
Ellis, Albert
Hayes, Steven C.
Kessler, Irving
Kriyananda, Swami
Skinner, B. F.
Suzuki, D. T.
Titchener, Edward
Watts, Allan
Zettle, R. D.

CREDITS

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16 Neurocounseling[1]

Learning Goals

At the conclusion of this chapter, readers will:

- understand the history of neurocounseling
- be able to describe the wellness, strength-based, developmental, and structural biological nature of neurocounseling
- gain knowledge about key concepts of neurocounseling, including neuroplasticity; neurogenesis; attention, arousal, and focus; the limbic system and emotions; changes in brain functioning over the lifespan; empathy and mirror neurons; microskills relationship to neural networks; brainwaves; wellness, positivity, and neuroplasticity; and self-regulation
- be able to articulate the major techniques used in neurocounseling, including neuroeducation; assessing lifestyle; biofeedback and self-regulation skills (e.g., diaphragmatic breathing, mindfulness, and technological approaches to biofeedback); neurofeedback; and neuroscience-informed therapies, such as prolonged exposure therapy (PE) and eye movement desensitization and reprocessing (EMDR)
- understand the therapeutic process of neurocounseling
- gain familiarity regarding the social, cultural, and spiritual applicability of neurocounseling
- be aware of the efficacy of neurocounseling

This final chapter of the text provides a brief history of neurocounseling and its view of human nature. We, then, describe its key concepts; neurocounseling techniques and therapeutic process; social, cultural, and spiritual issues associated with neurocounseling; and neurocounseling efficacy research. We conclude the chapter by illustrating this approach with Jake, a member of the Miller family.

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Brief History of Neurocounseling

> [P]sychological science in the 21st century can and should become not only the science of overt behavior, not only the science of the mind, but the science of brain function. (Cacioppo & Decety, 2009, p. 17)

Neurocounseling is an emerging and complex modality, increasingly being integrated into the counseling process (Field et al., 2017). Its history, however, can be traced back to the beginnings of counseling theory development. In fact, in the late 1800s Freud, who was trained as a neurologist, at first believed there was an intimate connection between neural processing and psychological states and that manipulation of structures in the brain would lead to answers of most psychological problems (Miller & Katz, 1989; Northoff, 2012). But "modern day" manipulation of physiology in mental health treatment occurred a bit later (Chatters et al., 2017). For instance, during the 1930's *Edmund Jacobson* (1938) identified progressive muscle relaxation as a method to assist in the treatment of psychosomatic disorders. During the 1960s biofeedback used instruments, such as thermometers and electrocardiograms, to help clients track and ultimately change physiological responses so people could achieve deep relaxation, sleep better, and control other body functions to increase wellness (Tart, 1969). Since that time, biofeedback has been used to "teach self-regulation of physiological processes" (Myers & Young, 2012, p. 21) and has progressed to include achievement of peak performances in athletes, meditators, and others (Field et al., 2017).

By the end of the 1960s, *Joe Kamiya*'s (1969) studies on consciousness demonstrated that by using a simple reward system, people could learn to alter their brainwave patterns, offering the first electroencephalogram (EEG) neurofeedback (NFB) training. This allowed individuals to distinguish *alpha waves* from other brainwaves and, ultimately, enter an alpha state that is more associated with relaxation and stress relief. This type of training progressed to the treatment of many behavioral and biological processes that helped focus attention and concentration and relieve anxiety and posttraumatic stress disorders.

Whereas *biofeedback* utilizes feedback from body activity, *neurofeedback (NFB)* employs feedback from brain activity (Crockett et al., 2017). Thus, NFB, which has also been called "biofeedback for the brain" (Russell-Chapin, 2016, p. 94) or *EEG biofeedback*, is a more specific form of biofeedback (Moss, 1998; Neurofeedback Alliance, n.d.). The goal of biofeedback and neurofeedback is to enable a person to take a more active role in self-mastery of behaviors and emotions for health maintenance and recovery.

Using instruments and techniques, clients can track and change physiological responses, a process called *self-regulation*, to promote wellness and enhance functioning (Moss, 1998). Self-regulation involves the ability to consciously focus attention, become aware of environmental factors and our physical and emotional reactions, bring memories of previous successful adaptations to bear in the present situation, and regain an emotional state and sense of well-being useful to resolve current distress or challenges (Ford & Blaustein, 2013). Neurofeedback procedures can provide a mechanism for self-regulation by helping individuals regulate what were previously thought of as nonvolitional neural functions (Thibault et al., 2015).

Continuing advances in *positron emission tomography (PET) scans*, *functional magnetic resonance imaging (fMRI)*, and the modern use of an *electroencephalogram (EEG)* have created a paradigm shift for counseling and psychology, as they can demonstrate the intimate relationship between our brainwaves and our biomechanics (Ivey & Zalaquett, 2011; Ivey et al., 2018). In fact, today, we can measure changes in the brain during normal conversation or during individual counseling. We can also show how skills, such as listening, empathy, and behavioral, cognitive, and interpersonal therapy can lead to positive feelings and corrective behaviors and the development of new neural pathways (Grawe, 2007; Montes, 2013). Research also demonstrates that social conditions, such as trauma, poverty, abuse, or harassment, can measurably harm

the development of the brain (Clearfield & Niman, 2012; Likhtik et al., 2008; Zalaquett & Ivey, 2014; Zalaquett et al., 2018).

Affirming the importance of neuroscience and psychotherapy, at the 100th anniversary of the New York State Psychiatric Institute of Columbia University, *Eric Kandel* (1998) noted that new learning alters the expression of genes, which results in structural changes in the brain, and postulated that psychotherapy would also produce such changes:

> Insofar as psychotherapy or counseling is effective and produces long-term changes in behavior, it presumably does so through learning, by producing changes in gene expression that alter the strength of synaptic connections and structural changes that alter the anatomical pattern of interconnections between nerve cells of the brain. (p. 460)

One of the first appearances of the word *neurocounseling* was in a 2013 edition of *Counseling Today,* in which it was defined as the integration of counseling and neuroscience to provide specific interventions to mental health concerns (Montes, 2013). Within this article, one of the leaders in the neurocounseling field, *Lori Russell-Chapin*, stated, "I'd been saying to graduate students for years, once we know more about the brain, it's going to change how we do therapy ... I really do think the brain is the final frontier ..." (p. 33). She went on to note that neuroscience represents the "physiological underpinnings of many of our mental health concerns. Helping clients better understand that our brains and bodies are constantly working together to create healthy living or dysregulated living is a must" (Russell-Chapin, 2016, p. 93). Sometimes called the newest force in counseling, this approach tends to be client-centered and supports a *strength-based* wellness model (Crockett et al., 2017).

Pioneering the integration of neuroscience in counseling and therapy, *Allen Ivey*, *Mary Bradford Ivey*, and *Carlos Zalaquett* began integrating relevant neuroscientific evidence into their textbooks and publishing articles, describing how neuroscience was confirming the effectiveness of counseling and therapy practices and its importance for social justice work (Ivey & Zalaquett, 2011; Zalaquett & Ivey, 2014). At a keynote address at the 2013 American Counseling Association's (ACA) national conference, Allen Ivey described how the integration of neuroscience findings was essential for the future of the discipline. For example, negative stress leads to neuronal damage, which manifests as symptoms of mental health concerns, whereas a positive therapeutic relationship helps establish new neural pathways and improve mental health (Montes, 2013). *Chad Luke*, another expert on neuroscience in counseling, has also written and talked extensively on the subject.

Neuroscience has the potential of changing how we view and diagnose mental health issues. Recently, the National Institute of Mental Health developed a *research domain criteria (RDoC)* initiative that offers a potentially new direction to traditional diagnosis procedures that are based on the *Diagnostic and Statistical Manual* (*DSM*-5; APA, 2013; Insel, 2013; Kozak & Cuthbert, 2016). By examining the relationship among psychopathology, psychology, and biology (e.g., genetics and neuroscience), it is hoped there could be a new classification system that is based on observable behaviors and neurobiological measures.

Today, there is increased interest in neurocounseling among all the helping professions, and we are beginning to see neuroscience information infused in counseling theory and skills textbooks (e.g., Ivey et al., 2017; Luke, 2016; Zalaquett et al., 2018). In addition, neuroscience offers specific modalities that focus on brain-based counseling, such as biofeedback, neurofeedback, self-regulation, *eye movement desensitization and reprocessing (EMDR)*, and *prolonged exposure (PE) therapy*. It also provides a potential foundation for new theoretical models, based on observable behaviors and neurobiological measures (Insel, 2013). As we move into the 21st century, we will

very likely see increased integration of neuroscience into counseling and the development of theoretical models based on such integration.

View of Human Nature

Neurocounseling is a *wellness* and *strength-based* approach that integrates *neuroeducation*, a form of psychoeducation, regarding how activities and environment affect general health and the *structural biology* of the brain. Optimizing health and *lifestyle* increases wellness and reduces stress and stimulates *neuroplasticity*, a condition required for successful neural change (Davidson & McEwen, 2012; Miller, 2016). Although some stress can be helpful and necessary for optimal development, when stress becomes overwhelming it begins to damage neural networks (Ivey et al., 2018). In contrast, living a healthy lifestyle in multiple dimensions equates to greater well-being and self-regulation, reduces stress, and lessens the potential for damage to neural networks.

Specific lifestyles can positively or negatively impact one's neuroplasticity. For instance, *physical exercise* has been found to encourage neuroplasticity and improve mental functioning (Rock et al., 2012; Russell-Chapin, 2017a, 2017b). Exercise releases *brain-derived neurotrophic factors (BDNF)*, which helps neurons grow, mature, and maintain themselves and is a major factor in neuroplasticity (Bliss & Cooke, 2011; El-Sayes et al., 2018; Jones, 2017a). Regarding nutrition, research into the *gut–microbiome–brain connection* is exploring implications for anxiety and depression, and a diet high in processed foods appears to contribute to *brain dysregulation* (Russell-Chapin, 2017b). *Sleep hygiene* (e.g., adequate sleep) plays a critical role in the consolidation of memories, emotional control, and even creativity (Rock et al., 2012). Additionally, during sleep, *glial cells* become active and play a key role in removing brain waste via the *glymphatic pathway*; however, when sleep is insufficient, toxins accumulate, and brain function is compromised (Benveniste et al., 2017; Russell-Chapin, 2017b).

In addition, *lifestyle habits* can also impact neuroplasticity. For instance, Ivey et al. (2014) assesses several areas of a person's *lifestyle* and, through psychoeducation, help clients focus on areas where functioning is low. These areas include exercise, nutrition, sleep, social relations, intimacy, cognitive challenge, cultural health and cultural identity, meditation, drug and alcohol use, medication and supplement use, positive thinking, spirituality, nature, smoking, screen time, relaxation and having fun, education, money and privilege, helping others, joy and humor, and art, music, and dance. By understanding how lifestyle affects brain health, the *neurocounselor* can help clients focus on those areas that need improvement and provide them with the motivation to make real, concrete, changes toward better neural functioning (Miller, 2016).

Neurocounseling has a *developmental focus*, and neurocounselors must have knowledge of neurobiological changes in the brain that occur throughout life and associated emotional and behavioral responses if they are to offer informed, effective interventions (Codrington, 2010; Lorelle & Michel, 2017). Brain development begins in the womb and occurs throughout the lifetime, and early detrimental influences to brain development, such as toxins, disease, and abuse, can impact a person over their lifetime (Konkel, 1998; Centers for Disease Control and Prevention [CDC], 2022). Although major changes in the brain occur until age 24 (Arain et al., 2013), the brain continues to change over one's lifetime, and despite some decline in ability after the age of 40, some neuroplasticity continues throughout one's lifespan. This is why knowledge of developmental brain changes, and their consequential challenges, must be incorporated into neuro-informed counseling (Luders, 2014; Singh-Manoux et al., 2012).

Critics of neurocounseling suggest it offers a reductionist view of human behavior that disregards the experiential nature of counseling, offers an objectivist medical model of intervention, and is antithetical to the humanistic foundations of counseling (Hansen et al., 2014; Wilkinson, 2018). Wilkinson (2018) argues that neuroeducation is simply a specialized form of

psychoeducation and biofeedback, rooted in behaviorism. Russell-Chapin (2017b), in contrast, asserts that because the tools of neurocounseling provide physiological self-regulation, it is, in fact, a strength-based theory.

Some have offered methods for integrating neuroscience into the counseling practice without losing the integrity of the counseling relationship. For instance, Luke et al. (2019) suggest that neuro-informed counseling can help counselors understand the human experience and help clients understand and normalize their experiences. Although this may seem counterintuitive for those who view neurocounseling as reductionistic and formulated from the medical model, understanding physiological factors can be empowering for clients, and offering information regarding ways of eliminating toxins can encourage neuroplasticity and enhance motivation for change. The integration of neuroscience and counseling presents a person-first model of counseling in which neuroscience is utilized as another tool to support clients in achieving their therapeutic goals (Bergstrom et al., 2014; Sullivan et al., 2018).

Key Concepts

This section examines central concepts of neurocounseling that include neuroplasticity; neurogenesis; attention, arousal, and focus; the limbic system and emotions; changes in brain functioning over the lifespan; empathy and mirror neurons; microskills relationship to neural networks; brainwaves; wellness, positivity, and neuroplasticity; and self-regulation.

Neuroplasticity

Neuroplasticity is "the ability of the brain to alter its structure and function in response to external or internal changes in the environment, including development, learning, memory, brain injury, and disease" (Field et al., 2017, p. 261). In other words, the brain can undergo structural changes as a result of events such as injury, illness, and stress; wellness activities and stress reduction; and through learned experiences (Davidson & McEwen, 2012; Tardif et al., 2016). If exposed to healthy stimuli, throughout the lifespan new connections and new *neural networks* can be developed, and the brain can rewire itself as connections between, and relative strength of, *neurons* become stronger (Schwartz & Begley, 2003).

The counseling process engages the brain to build new neural networks by guiding clients in visualizing new realities, exploring unique beliefs, and practicing alternative behaviors (Ivey et al., 2018). The result is new neural pathways that become stronger through the repeated, guided practice that the counseling process provides (Lillard & Erisir, 2011; Ratey, 2008). Mental health disorders, including depression, bipolar disorder, autism, schizophrenia, and drug addiction, inhibit neuroplasticity (Collingridge et al., 2010). Effective counseling can, however, permanently and positively change neural networks and how people feel, think, and behave.

Neurogenesis

Neurogenesis can be described as the brain's ability to regrow damaged or lost neurons from stem cells, which are undifferentiated cells that can morph into any of a number of different types of cells, including neurons. This process contributes to positive neuroplasticity (Ivey et al., 2018; Jones, 2017a). Although neurogenesis occurs throughout one's lifetime, it decreases as one ages (Alvarez-Buylla & Lim, 2004); however, healthy activities can ensure the optimal level of neurogenesis as a function of one's age and genetics.

Attention, Arousal, and Focus

Attention is essential to acquire, update, and correct learning and understanding and can be assessed through brain imaging (Lodge & Harrison, 2019). When a client and counselor attend to each other, the brains of each become focused and changes in brain chemistry, and structure, over time, can be seen. Attention involves two processes: arousal and focus. *Arousal*, in contrast with sleep, involves the turning on of a network of neurons in the brain stem called the *reticular activating system*. Once aroused, the executive functions of the *frontal cortex* can determine the direction of attention (Ivey et al., 2018). The ability to *focus* one's attention on certain activities, such as counseling, can positively affect brain development and how one thinks, acts, and feels. For instance, focused relaxation and meditation "can actually alter gene activity—the way that genes express themselves and thus influence the body" (Benson & Proctor, 2010, p. xii). Thus, learning how to control one's arousal and focus can lead to well-being (Goleman, 2020).

The Limbic System and Emotions

The *limbic system*, which consists of the *hypothalamus*, *hippocampus*, *amygdala*, and other areas of the brain, is often called the seat of human *emotions*. It lies below the *cerebrum*, which contains the *cerebral cortex* (gray matter) that controls *executive functioning* (see Figure 16.1).

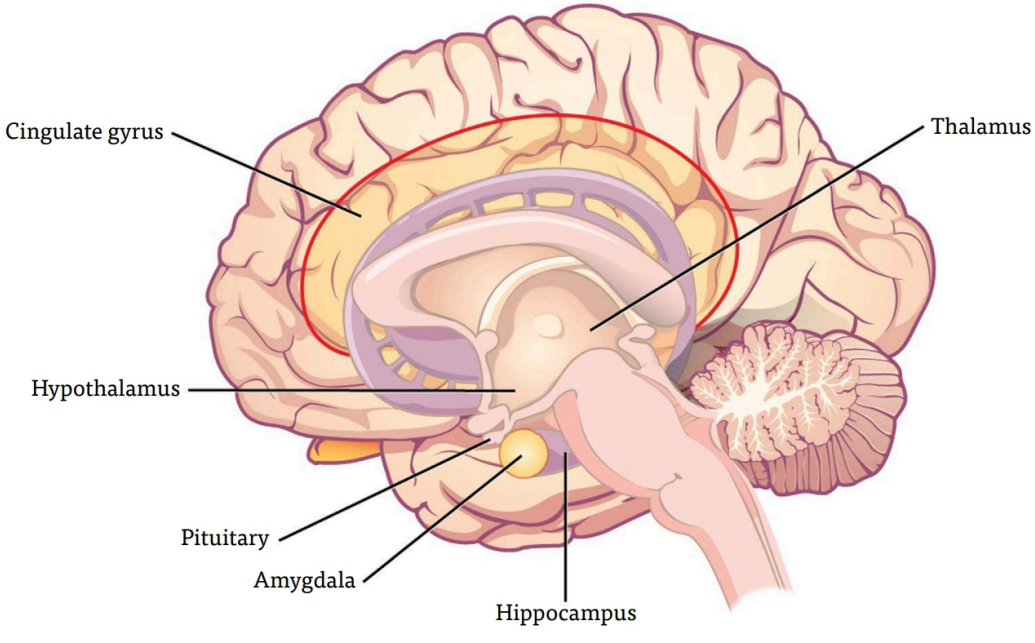

FIGURE 16.1 The Limbic System

The fact that the limbic system lies below the *cerebral cortex* is metaphorically interesting, as it is the cerebral cortex that can put breaks on the emotions of the limbic system. Sometimes, in severe stress or emotional overload, however, the limbic system can overwhelm the control held by the cerebral cortex. In fact, starting in the 1930s and until the 1980s, *prefrontal lobotomies*, a surgical procedure to sever the connection between the limbic system and the *prefrontal cortex*, were conducted on thousands of individuals, almost always leaving the person affectless, passive, and lacking motivation (see Box 16.1).

BOX 16.1 Lobotomies in America

> As those who watched the procedure described it, a patient would be rendered unconscious by electroshock. Freeman would then take a sharp ice pick-like instrument, insert it above the patient's eyeball through the orbit of the eye, into the frontal lobes of the brain, moving the instrument back and forth. Then he would do the same thing on the other side of the face (National Public Radio, 2005, para. 8).

During the 1930s through the 1950s, between 40,000 and 50,000 lobotomies were performed, mostly on individuals with schizophrenia and severe depression, in an effort to reduce their affect. These procedures involved drilling holes in the patient's skulls to access their brain or inserting an ice pick-like instrument through the eyeball into the frontal lobes. For these gruesome surgeries, which would seriously blunt a person's affect, change their personality, or even kill them, the originator of the procedure, Antonoi Egas Moniz, received the Nobel Prize (Tartakovsky, 2019)!

The limbic system's amygdala is where feelings of sadness, anger, pleasure, and fear reside, and it also helps to store memories so similar events associated with certain feelings can be remembered. Along with the hypothalamus and the pituitary and adrenal glands, the amygdala functions as an important coping mechanism when faced with stress and danger.

Changes in Brain Functioning Over the Lifespan

Neurocounselors must have knowledge of the neurobiological changes in the brain that occur throughout the lifespan and associated emotional and behavioral responses if they are to incorporate informed, effective interventions with their clients (Codrington, 2010; Lorelle & Michel, 2017). Brain development begins during pregnancy and occurs throughout the lifetime, though early detrimental influences, such as diseases (e.g., rubella), prenatal alcohol consumption, nutrition deficiencies, stress, and toxins (e.g., lead paint) can impact a person over their lifetime (CDC, 2022; Konkel, 1998).

Lifespan changes can be significant and observable in sessions with children or adolescent clients. The prefrontal cortex, heavily involved in executive functioning, rewires itself from puberty to 24 years old (Arain et al., 2013) and serves a crucial role in rational decision making. However, changing hormones and the impact of the limbic system can cause havoc on one's rational decision making and produce more emotionally driven or volatile behavior, especially during adolescents (Siegel, 2013), explaining why adolescent thoughts and behaviors may appear disorganized, selfish, incomplete, or irrational to a counselor (Lorelle & Michel, 2017; Xi et al., 2011). This is one of the reasons play therapy is particularly helpful for young children but not as useful for adolescents (Jones, 2017b).

As humans age past their mid-20s, the *myelin sheath* that surrounds neurons begins to degrade, which results in the slowdown of brain receptors. Every decade after the age of 40, the human brain decreases in volume and weight by approximately 5%, and there is a continual decline in ability to recall memories, learn new information, or utilize reasoning skills (Luders, 2014; Singh-Manoux et al., 2012); however, some neuroplasticity continues throughout one's lifespan, and knowledge of developmental brain changes and their consequential challenges should be incorporated when practicing neuro-informed counseling.

From a neurocounseling perspective, treatment and intervention is informed as much by developmental stage as by presenting symptoms, disease, injury, or trauma. The brain continues to

develop and change throughout the lifespan, and this understanding helps a clinician form richer and fuller case conceptualizations and treatment plans for their clients (Jones, 2017b).

Empathy and Mirror Neurons

Behaviors of others can be unconsciously taken in by an observer and mimicked. For instance, when one is around someone who is depressed, that person may unconsciously show those same expressions of sadness, thus reinforcing a cycle of sadness. In contrast, when one listens with energy and interest, others may pick up this positive affect.

> Expressions can ... transmit emotions to others—the sight of a person showing intense disgust turns on in the observer's brain areas that are associated with the feeling of disgust. Similarly, if you smile, the world does indeed smile with you (up to a point). Experiments in which tiny sensors were attached to the "smile" muscles of people looking at faces show the sight of another person smiling triggers automatic mimicry—albeit so slight that it may not be visible. ... the brain concludes that something good is happening out there and creates a feeling of pleasure. (Carter 1999, p. 87)

The imitation of emotional expression is mediated by *mirror neurons*, which are parallel neurons in the observer that fire when that person watches another individual behave. In other words, mirror neurons allow one to mimic the experience of others and understand the basis of the other person's experience.

The ability to imitate the behaviors of others suggests that, "The basic building blocks [of empathy] are hardwired into the brain and await development through interaction with others ..." (Decety & Jackson, 2004, p. 71). An empathic counselor can experience the world of the client due to mirror neurons, and the client's mirror neurons can be awakened, as the counselor demonstrates *empathy*. In other words, the counselor is demonstrating empathy, and the client is learning about empathy, as they experience the counselor's empathy. Thus, "Being empathic with patients may be more than just something that helps them 'feel better'; it may create a new state of neural activation with a coherence in the moment that improves the capacity for self-regulation" (Siegel, 2006, p. 255).

Decety and Jackson (2004, 2006) point out that those with an antisocial, criminal personality have a reduced ability to appreciate the emotions of others. Not only is there less firing of mirror neurons, but there also appears to be a dysfunction of the energizing amygdala and hippocampus (long-term memory). It is possible that training in empathy, and related microskills, may increase the effectiveness of our mirror neurons and diminish other nonempathic responses (Ivey et al., 2018).

Microskills Relationship to Neural Networks

Recognizing the dynamic interaction between our environment and our neural networks, some traditional therapeutic interventions, such as *microskills*, have been found to change neural networks. Microskills are the basic foundational skills involved in effectively helping relationships (Ivey et al., 2018), and new technological developments in neural imaging have allowed clinicians to see that microskills affect neural networks in areas of the brain responsible for positive client outcomes (Ivey et al., 2017, 2018; Kawamichi et al., 2015). Neuroplasticity is the process that allows for the rewiring of the brain that can result in emotional, behavioral, and cognitive improvements for the client (Ivey et al., 2017).

Brainwaves

Brainwaves, produced by synchronized, or repetitive, electrical pulses from neurons communicating with one another in our brain, are the foundation of all our thoughts, emotions, and behaviors. Brainwaves change according to what you are doing and feeling. Slow-frequency brainwaves predominate when we are resting, sleepy, or tired. Fast-frequency waves predominate when we are focused, very alert, or wired.

FIGURE 16.2 Individual With Electrodes Attached to Scalp

There are five types of brain waves, each measured by the frequency at which they register on the *electroencephalogram (EEG)*. Brainwaves are measured in hertz (cycles per second). The EEG is an instrument that detects electrical activity in the brain, using small metal discs (electrodes) attached to the scalp (Mayo Clinic, 1998–2022a). Individual brainwave presentations correlate to specific client concerns and through neurofeedback and other practices, clients can work to change and regulate these patterns, thus resulting in more positive feelings, thoughts, and behaviors (Russell-Chapin, 2016). Counselors can use brainwaves to diagnose, monitor, treat, and assess outcomes of interventions (see Figure 16.2).

Field et al. (2017) outline the five categories of brain waves and their potential functions, which are listed based on the frequency of hertz (Hz), a measurement of cycles per second (Ehlers & Kupfer, 1997):

- **delta waves (1–3 Hz):** The slowest of brainwaves, delta waves are generated during deep relaxation, meditation, and dreamless sleep. They seem to be most related to empathy, healing, and regeneration. On average, women seem to have more delta wave activity.
- **theta waves (4–7 Hz):** This twilight state occurs when one is falling in and out of sleep, or daydreaming, and can be readily achieved in meditative states. This state is deeply relaxing and is often considered the gateway to creativity, learning, memory, and intuition.
- **alpha waves (8–15 Hz):** Sometimes called the resting state of the brain, alpha waves are related to relaxed consciousness, calmness, decreased stress, and mind–body integration.
- **beta waves (16–31 Hz):** These brainwaves dominate one's waking state and are related to alertness, being attentive, problem solving, focused mental activity, decision-making, unease, anxiety, depression, and fight and flight.
- **gamma waves (32–100Hz):** Gamma waves oscillate quickly and are often associated with conscious awareness, perception, innovation, and "bursts of insight" (Field et al., 2017, p. 144). Some evidence suggests there is a relationship between gamma waves and schizophrenia and autism (Hirano et al., 2015; Rojas & Wilson, 2014).

Wellness, Positivity, and Neuroplasticity

Raising a client's consciousness regarding the mind–body interaction is key to neurocounseling. For instance, it is important to help clients know there is a connection between chronic stress and depression, anxiety, bipolar disorder, schizophrenia, and posttraumatic stress disorder (Douthit & Russotti, 2017) and that too much stress can inhibit neuroplasticity, while a reduction in stress can enhance it (Davidson & McEwen, 2012; Tardif et al., 2016). After clients gain this knowledge, focusing on *wellness* and *positivivity* can lead them to make choices that will strengthen the ability of the brain to make new neural networks. For example, the neurotransmitter dopamine is released when situations are pleasant and positive, preparing the brain for new learning and the development of new neural networks. In contrast, extreme toxins, abuse, trauma, making poor lifestyle choices, and negative thinking can result in the loss of neural connections (Kahneman, 2011).

Counselors who focus primarily on negative issues and problems build a self-reinforcing circularity between the demons of the amygdala and the frontal cortex. In contrast, wellness activities, such as exercise, positive reframing of old stories, enhancing interpersonal relationships, meditation, leisure activities, and developing lifelong positive habits all facilitate one's ability to control and modify negative thinking and feeling. As the client discovers how to make positive lifestyle changes, there is a rewiring of the brain that reduces negative symptoms and improves wellness (Russell-Chapin, 2017b).

Self-Regulation

Self-regulation is the individual's ability to gain, or regain, a sense of control over one's physiology, behavior, cognition, and emotions in an effort to seek a more satisfying life. In fact, the goal of most counseling approaches is to learn how to regulate oneself. As one example, a primary goal of dialectical behavior therapy (DBT) is to assist with emotional regulation by learning how to moderate one's feelings, de-escalate emotional situations, and self-soothe (Moonshine & Schaefer, 2019). In addition to counseling, specific types of biofeedback and neurofeedback can also be part of the self-regulation process. By obtaining feedback about your body and mind states, one can learn how to move toward states of relaxation, emotional stability, and the development of new neural networks based on positive states of being.

Therapeutic Techniques

This section will review major techniques used in neurocounseling, including neuroeducation, assessing lifestyle, biofeedback and self-regulation skills (e.g., diaphragmatic breathing, mindfulness, and technological approaches to biofeedback), neurofeedback, and *neuroscience-informed therapies*, such as prolonged exposure therapy (PE) and eye movement desensitization and reprocessing (EMDR).

Neuroeducation

> Neuroeducation is a didactic or experiential-based intervention that aims to reduce client distress and improve client outcome by helping clients understand the neurological processes underlying mental functioning. (Miller, 2016, p. 105)

By understanding the neurological basis for their symptoms, clients begin to believe that change is possible. Understanding that change is achieved through practice and repetition and that it does not happen quickly also helps them cope with the unsteady pace of success and setbacks

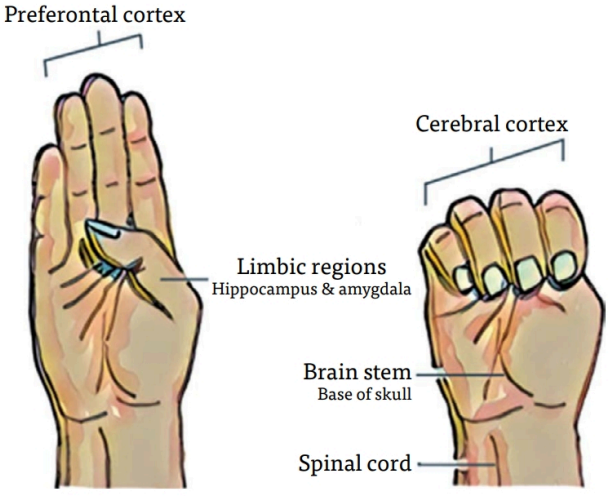

FIGURE 16.3 Hand Model of the Brain

in counseling (Miller, 2016). Thus, the neurocounselor provides *neuroeducation*, regarding basic structures and functions of the brain, to highlight the necessary interactions between the brain and behavior.

One simple way to help clients understand how brain structures influence emotional responses, and to learn techniques to mediate such responses, is the *hand model* of the brain (Jones, 2017a; Siegel, 2017). The lower part of the brain is represented by the wrist and thumb and reflects the spinal cord, brain stem, and limbic system, including the hippocampus and the amygdala (Figure 16.3). This is the emotional center of the brain, which also mediates the *fight or flight response*. The upper part of the brain, the *cortex*, is represented by the four remaining fingers, with the area around the tips of the fingers being the prefrontal cortex, and the area around the joints of the fingers being the cerebral cortex. The cortex allows one to think and use logic and moral reasoning. Sometimes, when individuals are too tired or are in situations that could trigger emotional dysregulation, the lower part of the brain can take over and *flip one's lid*, as is represented on the left side of Figure 16.3. But individuals can again gain control over the lower part of their brain. This is represented on the right side of Figure 16.3, where we see the prefrontal cortex wrapping itself over the lower part of the brain and communicating with the cerebral cortex in an effort to control the lower part of the brain. This model is an analogy for how individuals can learn specific techniques that encourage the upper part of the brain to fire (e.g., the use of specific cognitive techniques) and reduce responses from the lower part of the brain. This process is called using *neuroscience-informed interventions*.

As clients learn the neurological basis for their symptoms, through neuroeducation, they tend to experience an increase in compassion and empathy for self and others and a reduction in the shame they feel about their past behaviors (Miller, 2016). They also lower the likelihood of blaming others for their problems, as they realize their part in destructive relationships and that they can have some control of changing themselves.

Lifestyle Assessment

As clients increasingly understand the mind–body connection and have clarity about how behaviors affect their brain development and their thinking, feelings, and behaving, they are ready to assess those areas of their lives in which they may have undue stress or behaviors that can sabotage neural plasticity. One activity in which clients can obtain a *lifestyle assessment* is through Ivey and others' (2018) *Therapeutic Lifestyle Changes Inventory*. This instrument assesses 20 dimensions of life, and clients can rank order those areas they most want to work on (see Table 16.1).

Similar to Therapeutic Lifestyle Changes Inventory, Myers and Sweeney (2004) developed the *indivisible self model*, an evidence-based model of wellness that examines multiple aspects of one's life experience, including the creative, coping, social, essential, and physical self, and demonstrates the interrelated effects the dimensions have on the overall well-being of the individual. Finally, the *healthy mind platter* was developed as a model that provides a framework for optimal brain functioning facilitated through daily engagement in seven mental activities to enhance brain matter and well-being (Rock et al., 2012; Siegel, 2021; see Figure 16.4; Box 16.2).

TABLE 16.1. Therapeutic Lifestyle Changes Inventory

HOW HEALTHY IS YOUR LIFESTYLE? Allen Ivey, Mary Bradford Ivey, and Carlos Zalaquett © 2014

Name_____ Gender_____ Age_____

Race/Ethnicity_____ Date_____

Circle your response

ALIOSTRESS/EUSTRESS/STRESS LEVELS: What is your level of stress?

1	2	3	4	5	1	2	3	4	5
Eustress, life is generally calm and interesting, few major or minor stressors, recover from stress fairly quickly. Pleasant, happy life.	Manageable, stressors can be troublesome, but recover. Some tough stressors time to time. Life is good.	Often feel stressed, some times for days, loose some sleep, old stressful events often with me. However, generally life is good.	Constant feeling of stress, pressure, sleep problems, old events still with me. Can blow up, but manage. Life is OK, but ...	Chronic stress, tired, angry, sleep difficulties, feel sad, easy to blowup, fall apart, out of control. Need to change my life.					

1. Exercise: How frequently do you exercise (walk, swim, bike, garden, run, rock climb)?

1	2	3	4	5	1	2	3	4	5
5–7 days weekly	4–5 days weekly	2–3 times weekly	Occasional	Couch potato					

2. Nutrition: What is your typical diet?

1	2	3	4	5	1	2	3	4	5
Vegan, vegetarian, fish	Low fat, lean meat, fruit, vegetables	Mediterranean, Paleo	Stn. Amer. Diet	Fast food, fries, sugar					

3. Sleep: How many hours nightly, including how restful is your sleep?

1	2	3	4	5	1	2	3	4	5
7–9 hours	7 hours	Sleep challenges	Many meds	Serious difficulty					

4. Social relations: How connected are you to others—close relationships, family, friends, groups?

1	2	3	4	5	1	2	3	4	5
Well-connected	Connected	Friends, some groups	Somewhat social	Alone, angry, sad					

4a. Intimacy, Sex Life: How satisfied are you with your sex life?

1	2	3	4	5	1	2	3	4	5
Highly	Moderately	Somewhat	Dissatisfied	Do not care					

(*Continued*)

TABLE 16.1. (*Continued*)

5. Cognitive Challenge: How actively do you involve yourself in mind-expanding cognitive challenges?									
1	2	3	4	5	1	2	3	4	5
Joy in constantly learning, searching for the New	Involved, active	Moderately interested, reads some books, puzzles	Some, no more than 3 hours	None					
6. Cultural Health and Cultural Identity: Awareness of cultural issues influencing, you, including sense of cultural identity.									
1	2	3	4	5	1	2	3	4	5
Empathy for self & others. Sees self-in-relation, race/ethnicity, etc. awareness, life vision	At least two of the preceding plus life vision	One of the preceding, some life vision	Slightly aware of issues	Oppressive, no real life vision					
7. Meditation, Yoga, etc.: How often you engage in this practice?									
1	2	3	4	5	1	2	3	4	5
Daily	3–4 weekly	Aware, occasional	Absent	Hyper, cannot do					
8. Drugs, Alcohol: Use of alcohol or other drugs?									
1	2	3	4	5	1	2	3	4	5
None	Moderate	Has become part of life	Becomes a focus	Addicted					
9. Medication and Supplements: How aware are you of possible issues plus appropriate contact with physicians?									
1	2	3	4	5	1	2	3	4	5
Regular contact with physician, follows directions	Frequent contact	Occasional, some difficulty following directions	Seldom	Never					
10. Positive thinking/optimism/ happiness: Do you have resilient positive attitudes and a good level of happiness?									
1	2	3	4	5	1	2	3	4	5
Resilient, positive, optimistic	Most of the time	Usually, not always	Seldom	Infrequent					
11. Belief, Values: How engaged are you with living a meaningful life?									
1	2	3	4	5	1	2	3	4	5
A life center	Involved	Occasional involvement	Never	Not interested					

11a. Spirituality, Religiosity: Do you participate in spiritual or religious activities?

1	2	3	4	5	1	2	3	4	5
Daily	Between 2–4 days	Once a week	Holidays only	Do not believe					

12. Nature/Green/Garden: How often you engage in outside/nature activities?

1	2	3	4	5	1	2	3	4	5
Gets outdoors often	Frequent	Sometimes	Seldom	Almost never					

13. Smoking: Do you smoke? If yes, how much?

1	2	3	4	5	1	2	3	4	5
Never	Never, but exposed to secondary	Stopped smoking	Tries to stop	Still smoking					

14. Screen time (TV, Cell, iPad, Computer): Amount of time in front of a screen?

1	2	3	4	5	1	2	3	4	5
None	2 hours or less daily	4 hours	6 or more	Never off-line					

15. Relaxation and Having Fun: How frequently you involved in leisure or relaxation activities?

1	2	3	4	5	1	2	3	4	5
Something every day	5–6 hours weekly	3–4 hours	Limited & stressed	Workaholic and/ stressed out					

16. Education: What level of education have you completed?

1	2	3	4	5	1	2	3	4	5
College, serious hobby	College	Comm. College	High school/GED	Drop out					

17. Money and Privilege: What is your financial situation? Do you benefit from privilege because of race or other factor?

1	2	3	4	5	1	2	3	4	5
Have it all, privileged	Comfortable	Making it	On edge, but OK	Poor, oppressed					

18. Helping others/community involvement/social justice action: How frequently you help others or your community?

1	2	3	4	5	1	2	3	4	5
Daily action	Weekly action	Often involved	No time	Destructive					

19. Art, Music, Dance, Literature: How frequently you release your artistic abilities?

1	2	3	4	5	1	2	3	4	5
Daily	Several times weekly	Moderate/frequent	Occasional	None					

(*Continued*)

TABLE 16.1. (*Continued*)

20. Joy, Humor, Zest for Living, Keeping it Simple, Not Overdoing: How happy or how much fun do you have?									
1	2	3	4	5	1	2	3	4	5
Life is a blast	Fun most of the time	Moderately happy	Now and then	Never					
SELF-EVALUATION OF GENERAL LIFESTYLE									
Work: What is the level of your work or retirement activities?									
1	2	3	4	5	1	2	3	4	5
Fully employed. Retired, never bored	Partial Employment. Retired and active	Temporary Work. OK, but sometimes bored	Jobless. Bored, less happy	Given up work Inactive, depressed					
In Control: How much in control of your life are you?									
1	2	3	4	5	1	2	3	4	5
In full control of my life	Mostly in control	Somewhat in control	Low control	Out of control					
Health: How healthy are you?									
1	2	3	4	5	1	2	3	4	5
Very healthy	Occasional issues	Good, but could be better	Major issue	Very poor					
Stability: How stable is your life currently?									
1	2	3	4	5	1	2	3	4	5
Highly stable	Moderately	Some ups and downs	Unstable	Chaotic					
Resilience: Your ability to bounce back from life challenges									
1	2	3	4	5	1	2	3	4	5
Back "at it" soon	Temporarily troubled	Worry a fair amount	Difficult, but do it	Overwhelmed					
Satisfaction: How satisfied are you with your current lifestyle?									
1	2	3	4	5	1	2	3	4	5
Highly	Moderately	Somewhat	Dissatisfied	Helpless					
Action: How ready are you to make changes to increase your wellbeing?									
1	2	3	4	5	1	2	3	4	5
Ready to change	Want to change	Thinking about it	Some interest	Not interested					

Source: Carlos Zalaquett, Allen Ivey, and Mary Bradford Ivey, "Therapeutic Lifestyle Changes," *Essential Theories of Counseling and Psychotherapy: Everyday Practice in Our Diverse World*, pp. 46-50. Copyright © 2019 by Cognella, Inc. Reprinted with permission.

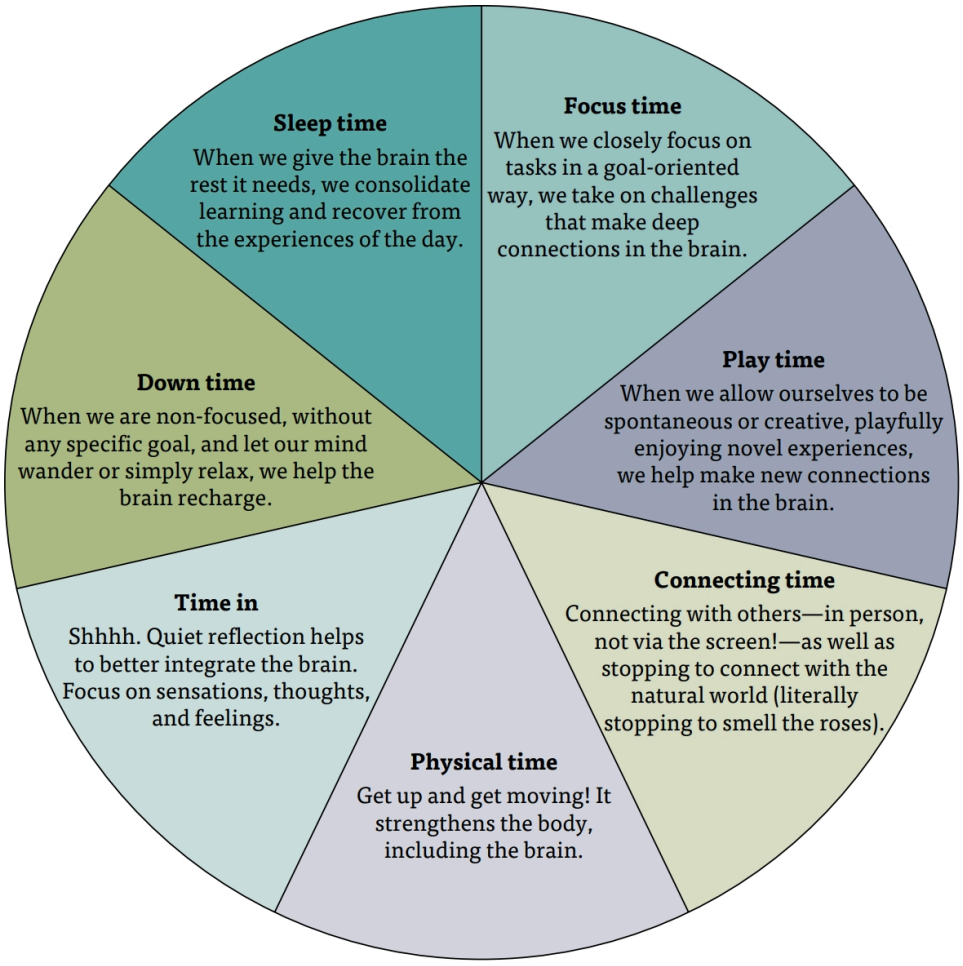

FIGURE 16.4 The Healthy Mind Platter

BOX 16.2 Focusing on Lifestyle Change

Using the Therapeutic Lifestyle Changes Inventory in Table 16.1, identify those areas where you received a score of three or higher. Then, using the seven mental activities of the healthy mind platter in Box 16.2, rank those areas from highest to lowest based on how much you tend to focus on that mental activity during your day. Then, using both lists, identify areas you need to work on to decrease stress and increase life satisfaction. As noted throughout the chapter, working on decreasing stress and focusing on positive change can increase neuroplasticity and make long-term changes in how one thinks, acts, and feels.

Biofeedback and Self-Regulation Skills

Because a primary goal of neurocounseling is to provide the client concrete ways to regulate physical responses to stress, it is helpful for clients to have a basic understanding of the physiology involved in stress activation and suppression (Russell-Chapin, 2017b). In simple terms, stress is experienced when the *sympathetic nervous system* is activated, and the *parasympathetic nervous*

system is suppressed and is reduced when the parasympathetic nervous system is activated, and the sympathetic nervous system is suppressed (Douthit & Russotti, 2017; Ivey et al., 2018). All stress is not harmful. For instance, sympathetic nervous system activation is a necessary condition for attention, motivation, processing information, immune function, and performance (Jones et al., 2017). Intense or prolonged levels of sympathetic nervous system activation, however, can lead to increased heart rate, blood pressure, and anxiety along with disruptions in sleep and dysregulation of the digestive and immune systems (Douthit & Russotti, 2017). Thus, a balance between the sympathetic and parasympathetic nervous systems is the goal, and when the *sympathetic nervous system* is consistently activated, and the *parasympathetic nervous system* is consistently suppressed, negative emotional, physical, and cognitive outcomes are experienced and intervention becomes necessary (Crockett et al., 2017; Ivey et al., 2018; Jones et al., 2017; Russell-Chapin, 2017b). *Self-regulation* skills that shift the activation from the sympathetic to the parasympathetic system can lower heart rate and blood pressure, reduce anxiety, and restore immune and digestive function (Douthit & Russotti, 2017).

The first step in utilizing *self-regulation skills* is instilling in the client a realization that the response to a stressor does not need to be automatic; there is a difference between a reaction and a response, and once this is recognized, one can learn how to physiologically respond in a different way (Russell-Chapin, 2017b). Understanding that stress from activation of the *fight or flight response* can be regulated through self-regulation techniques provides clients a framework from which to view such skills (Russell-Chapin, 2017b). Although many techniques can be used to assist in self-regulation, three popular approaches are *diaphragmatic breathing*, *mindfulness*, and technological approaches to *biofeedback*.

Diaphragmatic Breathing

An imbalance between the parasympathetic and sympathetic systems often involves slow, irregular, and shallow breaths, which are associated with distress, including anxiety, depression, and trauma (Crockett et al., 2017). *Diaphragmatic breathing*, by engaging the diaphragm in full, deep breaths, increases the absorption rate of glucose and oxygen, improving overall well-being and reducing anxiety, as the brain mechanisms involved in calming and relaxing begin to engage (Crockett et al., 2017; Russell-Chapin, 2017b). In sessions, once the client understands the basic associated neurobiology of healthy breathing, neurocounselors can lead guided breath awareness exercises to help clients notice and address irregularities within their own breathing, including "pace, depth, use of nose versus mouth, location of movement, volume, inhale/exhale ratio, texture, comfortability, ease, and difficulty" (Crockett et al., 2017, p. 171).

Mindfulness

Mindfulness is another technique that can be used to teach clients self-regulation skills (Russell-Chapin, 2017b). An introduction to mindfulness often involves focusing on how all the senses perceive a given experience, such as eating a favorite food or spending time with a loved one and noticing the characteristics of the experience without judgment (Crockett et al., 2017; Russell-Chapin, 2017b). As clients understand the application of mindfulness by using simple, concrete examples, they become more adept at focusing on the present, while withholding judgment. It is then that they can comprehend the connection between external stimuli and their internal reactions and begin to develop an ability to change their reactions through attention and focus (Crockett et al., 2017; see Box 16.3).

BOX 16.3 Mindfulness Exercises

The Mayo Clinic (1998–2022b) has several easy suggestions for practicing mindfulness exercises. After you examine the following exercises, pick one or two, and practice it for the next week. See how it may positively affect your stress and anxiety level and, if conducted over long periods, can positively impact your neuroplasticity:

- **Pay attention.** It's hard to slow down and notice things in a busy world. Try to take the time to experience your environment with all of your senses—touch, sound, sight, smell and taste. For example, when you eat a favorite food, take the time to smell, taste, and truly enjoy it.
- **Live in the moment.** Try to intentionally bring an open, accepting, and discerning attention to everything you do. Find joy in simple pleasures.
- **Accept yourself.** Treat yourself the way you would treat a good friend.
- **Focus on your breathing.** When you have negative thoughts, try to sit down, take a deep breath, and close your eyes. Focus on your breath, as it moves in and out of your body. Sitting and breathing for even just a minute can help.

You can also try more structured mindfulness exercises, such as:

- **Body scan meditation.** Lie on your back with your legs extended and arms at your sides, palms facing up. Focus your attention slowly and deliberately on each part of your body, in order, from toes to head or head to toes. Be aware of any sensations, emotions, or thoughts associated with each part of your body.
- **Sitting meditation.** Sit comfortably with your back straight, feet flat on the floor, and hands on your lap. Breathing through your nose, focus on your breath moving in and out of your body. If physical sensations or thoughts interrupt your meditation, note the experience and then return your focus to your breath.
- **Walking meditation.** Find a quiet place 10 to 20 feet in length, and begin to walk slowly. Focus on the experience of walking, being aware of the sensations of standing and the subtle movements that keep your balance. When you reach the end of your path, turn and continue walking, maintaining awareness of your sensations. (Mayo Clinic, 1998–2022b, What Are Some Examples of Mindfulness Exercises? section).

Technological Approaches to Biofeedback

Various technological approaches to biofeedback are available to teach self-regulation skills that focus on decreasing muscle tension, decreasing skin conductance, maintaining body temperature, lowering respiration and heart rates, and lessening heart rate variability (HRV), all of which require specific training and equipment (Crockett et al., 2017; Russell-Chapin, 2017b). Neurocounselors may wish to receive comprehensive or specialized training (Crockett et al., 2017) or refer to trained clinicians when appropriate. Similar to the nontechnological self-regulation strategies previously described, technological approaches to biofeedback teach clients how to engage in self-regulation by providing biofeedback that will result in decreased stress, improved performance, increased resiliency, and improved health. Eventually, the client learns how to engage in such self-regulation outside of sessions and without technology-provided biofeedback (Crockett et al., 2017; Russell-Chapin, 2017b; see Box 16.4).

BOX 16.4 Using Biofeedback to Reduce Stress

Next time you are in a state of stress, take your pulse. Then, practice one or two of the mindfulness exercises in Box 16.3 for about 10 minutes. Then, take your pulse again. Has it gone down? If yes, this nontechnological approach is one indicator of how you can control your bodily states. With the use of technology, feedback can involve monitoring biological states you cannot normally monitor on your own (e.g., blood pressure, brain waves, galvanic skin response, etc.) and ultimately change your neural networks.

Neurofeedback

Neurofeedback as a clinical approach to the resolution of psychological and behavioral problems has its origins in the study of the brain's electrical activity and behavioral psychology. The development of the human electroencephalogram (EEG) combined with the application of principles of learning, knowledge of the brain's neuroplasticity, and principles of biofeedback and self-regulation, have made it possible to detect, monitor, and change the brain's electrical activity related to many emotional and physiological disorders. (Chapin & Russell-Chapin, 2014, p. 87)

Neurofeedback (NFB) is administered by a trained clinician and involves measuring and identifying brainwaves and teaching clients how to self-regulate them (Chapin & Russell-Chapin, 2014). A noninvasive treatment, electrodes are attached to the scalp to read the electrical activity of the brain, which is displayed and analyzed through computer software programs (Collura, 2014). Relying on the principles of operant and classical condition, NFB depends on reinforcers and inhibitors to teach a client how to self-regulate the electrical activity of their brain (Chapin & Russell-Chapin, 2014; Collura, 2014). Electrical activity is measured in terms of brain waves, and the amplitude of specific brainwaves correlates with mental states. Changes to the brain wave patterns work to address psychological symptoms or behaviors. Changing brainwave activity can occur through simple operant conditioning techniques. For instance, after the counselor solicits favored puzzles, games, music, or movies from the client, when desired brain waves are produced, the reward of the chosen activity is produced (e.g., the music will play, or the puzzle will unfold), and when the brain waves remain dysregulated, the reward is withheld (e.g., the music stops, or the puzzle freezes). As part of a thorough client assessment, NFB can be used to determine irregularities in brainwaves and coupled with the information gained through a comprehensive biopsychosocial evaluation, and protocols to address these brain wave irregularities can be selected as part of the treatment plan. As the client learns to achieve the desired brain wave patterns through regular sessions, NFB works as another tool to develop self-regulation abilities that clients can learn to utilize in daily life (Russell-Chapin, 2016).

Neuroscience-Informed Therapies

Although there are a number of therapies that have been informed by neuroscience, two in particular have been popular in the past few years: prolonged exposure therapy and eye movement desensitization response. Here, we offer a very brief explanation of both.

Prolonged Exposure Therapy

Prolonged exposure (PE) therapy is an evidenced-based treatment for posttraumatic stress disorder (PTSD) and is commonly used with combat veterans and others struggling with PTSD (Neukrug, 2015; Stojek et al., 2018). Stojek and collaborators assert that traumatic events disrupt the networks of interconnected regions in the brain. PE increases the connectivity within and between the disrupted regions and re-establishes functional coherence between the ventromedial prefrontal cortex (vmPFC), amygdala, and the hippocampus. These processes increase the regulation of

emotional responses in stressful situations. In other words, PE rearranges the fear circuitry in the brain—amygdala, hippocampus, and prefrontal cortex.

PE therapy is performed in nine to 12 sessions of about 90 minutes of duration. When beginning PE, the goal of the counselor is to gather as much information as possible from the individual regarding the stress they are experiencing, while also providing psychoeducation to the client. The client is also provided with a "toolbox" of relaxation techniques in these earlier sessions. After rapport has been sufficiently built, and the client has been provided with ways to relieve agitation and stress that may arise from the process of PE therapy, the counselor will begin introducing exposure to traumatic events during the client's remaining sessions while the client practices relaxation exercises so that exposure to the traumatic events is no longer associated with a stress reaction (Mackinson & Young, 2012).

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) therapy was originally designed to treat trauma survivors, such as those who were experiencing posttraumatic stress disorder (PTSD). From a neuroprocessing perspective, EMDR is explained by the *adaptive information processing (AIP) model*, which suggests that neural pathways in the amygdala and hippocampus store traumatic memories that become trapped and not integrated within the wider adaptive memory network (EMDR Institute, 2020a; Shapiro, 2005, 2009; Shapiro & Forrest, 1997; Shapiro & Solomon, 2015). When a situation triggers this trapped memory, the memory becomes present, as if it is occurring in the present with all the physical, emotional, and perceptual experiences it originally had. These stored memories are targeted, and through the use of bilateral dual attention stimulation, such as eye movement or the use of taps or tones, the targeted memory becomes integrated within the general memory network and becomes part of the client's total life experience.

Why EMDR works is not totally clear, though it may have to do with how memory gets stored during rapid eye movement sleep (which this process seems to mimic), due to the stimulation of an automatic relaxation response that becomes increased through the process, or due to a decrease in the vividness of the disturbed memory as a byproduct of the process. In addition, some posit that past traumas can become embedded in our psyche, and that catharsis of embedded memories can lead to healing. Others have suggested that core beliefs maintain negative experiences and that new cognitions and behaviors, one goal of EMDR, helps a person adopt new ways of being in the world. In either case, EMDR treatment involves eight phases that sometimes can be completed within a few sessions but often take longer (EMDR Institute, 2020b; Shapiro & Solomon, 2015).

- **phase 1: client history and treatment planning:** In this phase, an in-depth history of the client is taken, and a treatment plan is formed. In particular, the therapist focuses on what the problem is along with the symptoms of the problem, situations from the past that caused the problem, current issues that continue distress, and those behaviors and skills needed in the future to alleviate the problem. In-depth discussion of the problem is not necessary; however, the client does need to identify what the problem is. Usually, this phase takes one to two sessions.
- **phase 2: preparation:** Generally lasting one to two sessions, but sometimes longer (depending on the issue), this phase involves building a trusting relationship through the use of empathy and related skills and the start of teaching the client a range of relaxation and coping techniques. Although EMDR is known for the use of eye movements, the therapeutic relationship should not be underestimated, as it is critical that the client "buy into" the process if it is to be successful (Dworkin, 2005). In addition, teaching a variety of cognitive-behavioral relaxation techniques and coping skills helps clients begin the process of self-managing their anxiety.

- **phase 3: assessment:** Using the problem situation identified in phase 1, the client in this phase isolates negative beliefs associated with the event. Such negative self-statements or core beliefs could be "I am not lovable," "I am worthless," or "I am not capable." After picking one or more negative beliefs, the client identifies positive beliefs that contradict the negative ones. Using the *subjective units of disturbance (SUD) scale*, the client rates their level of discomfort from 0 to 10, with 0 being the most relaxed within the context of the problem and a 10 being the most upset. The client can relay their rating when thinking about the negative event, negative self-statements, or the newly identified positive self-statement.
- **phase 4: desensitization:** During phase 4, the therapist has the client focus on upsetting images, negative beliefs, negative emotions, and physical sensations related to a traumatic or upsetting event. At the same time, the therapist directs the client in a series of eye movements or related stimulations (e.g., tapping or listening to rhythmic tones). Then, the therapist tells the client to "blank it out" (or "let it go") and take a deep breath and then asks, "What do you get now?" (Shapiro, 2002, p. 38). At this point, the therapist will continue with treatment based on the type of response the client gives. If the client is still bothered by the initial upsetting image and related symptoms, desensitization will be repeated; however, clients will often leave the initial image and move on to another image related to the traumatic event. A decision to move on is made if there is a SUD level of 0, 1, or 2.
- **phase 5: installation:** As clients' level of upset decreases, there is a natural increase in the positive cognitive beliefs they identified in phase 3. Thus, the purpose of this phase is to strengthen those positive beliefs. Using what is called the *validity of cognition (VoC) scale*, which runs from a 1 (completely false) to a 7 (completely true), the goal is to have clients reach the high end of the scale in reference to their newly chosen positive cognitive beliefs. In this phase, the therapist encourages pairing the positive cognition with the traumatic event. So a person who was verbally abused as a child and always told they were "stupid" will pair the image of being told they were stupid with a statement, such as, "I am capable and smart." Other activities might also be used at this time to reinforce the positive self-statement, such as the client deciding to confront a parent directly about the statements made in early life. This confrontation, if done correctly, could help to anchor the positive belief.
- **phase 6: body scan:** Because the body will sometimes continue to hold the tension from traumatic or upsetting events beyond what our minds are consciously saying, clients are asked to scan their bodies while remembering the target event. If tension is still present, additional processing is done (phases 4 and 5).
- **phase 7: closure:** The closure phase ensures that the client finishes each session feeling better than when the session began and helps clients focus on ongoing feelings of "psychological stability." Thus, at the end of each session, clients are encouraged to practice the self-management techniques learned in phase 2. In addition, clients are encouraged to keep an ongoing journal to record their progress, to practice the self-management techniques at home, and to use relaxation recordings at home to maintain their stability.
- **phase 8: reevaluation:** At the beginning of each EMDR session, the counselor reviews the client's journal with the client and talks with the client about any additional targets (problems) that need to be addressed. As processing continues, new issues will arise and the focus of treatment will change. As new issues emerge, clients will recycle through phase 3 to phase 8. And as new targets are dealt with, client anxiety, over time, will lessen, and psychological stability will be maintained without further treatments being necessary.

EMDR's success in treating a number of disorders and problems is promising, and this approach will very likely expand its research base to clearly define why it has been so efficacious (EMDR Institute, 2020c; Shapiro, 2005, 2009; Shapiro & Forrest, 1997; Shapiro & Solomon, 2015).

The Counseling Process

A neuroscience-informed approach will often start with a general clinical assessment of the client's problem. This assessment might include a traditional intake interview as well as a variety of qualitative and quantitative assessments focused on client wellness. Included in this assessment might be the Therapeutic Lifestyle Changes Inventory, the indivisible self model, or the healthy mind platter, discussed earlier. In addition, a *quantitative electroencephalogram (qEEG)* may be administered to capture brainwave presentations, which may be interpreted to correlate to possible behaviors or symptoms. Along with knowledge of developmental changes (Jones, 2017b), this assessment helps the neurocounselor perform a neuroscientific conceptualization of behaviors, emotions, thoughts, and feelings necessary to conduct intentional work with a client by focusing on a treatment plan and selecting appropriate interventions (Russell-Chapin, 2017a). The treatment plan will strengthen existing neural networks and identify, develop, and reinforce weak neural pathways.

Neurocounseling can stand on its own if the counselor is trained in structural biology, brain changes as a function of age, and the processes of neurofeedback. For instance, here a neuro-informed approach can focus on how modulating one's own brainwaves can positively impact lifestyle and how lifestyle can positively impact changes in brainwaves. Most counselors, however, are trained solely in a theoretical approach to counseling. Through workshops and courses on neurofeedback, counselors can begin to integrate neuro-informed treatments into their existing theoretical approach. Here counselors can share with clients the process by which chosen interventions will change neural networks and how such changes will translate into psychological and emotional improvement, increasing a client's agency in the change process (Miller, 2016).

Social, Cultural, and Spiritual Issues

The effect of stress on well-being and emotional health has been highlighted as a central concept to neurocounseling. As such, an understanding of how various sources of stress, including that suffered by victims of social injustice and oppression and members of marginalized groups, is fundamental to the successful implementation of counseling interventions (Hays & Gay, 2022; Ivey et al., 2018; Moody, 2019). For the neurocounselor, this understanding highlights not only the necessity of appropriate interventions through the course of counseling but also the importance of advocating for social justice issues to alleviate significant sources of stress for diverse populations (Douthit & Russotti, 2017; Zalaquett & Ivey, 2018). Key social justice issues, such as poverty, abuse, bullying, racism, sexism, heterosexism, discrimination, and other forms of oppression, are all stressful. Stressful events can curtail normal brain development in newborns and youngsters and negatively affect brain neurogenesis and plasticity in adults. Thus, these social justice issues are detrimental to the psychological, physical, and social well-being of individuals (Zalaquett & Ivey, 2014; Zalaquett et al., 2018).

Neurocounselors must exercise cultural competence in their work with clients, as they build upon an existing theoretical framework to incorporate neuro-informed elements, ensuring they are attending to cultural sensitivities, religious and spiritual differences, intersecting identities, and various physical needs (Douthit & Russotti, 2017). Advocacy for diverse and marginalized clients, who are most likely to be the victims of social injustice, is thus critical for neurocounselors. In general, more research is needed to demonstrate the efficacy of neurocounseling, but in particular, research is needed to explore applications with diverse populations.

Efficacy of Neurocounseling

As neurocounseling is still a relatively new approach, its efficacy with different populations is still being determined (Field et al., 2017). A number of populations, however, have been identified as possibly benefiting from a neuro-informed approach to counseling, including people affected by trauma, substance use disorders, attention-deficit/hyperactivity disorder, anxiety, depression, and other concerns.

Trauma

Counselors working with people affected by trauma should consider using neuroscience-informed interventions appropriate to the altered neural response patterns typical of this population (Jones et al., 2017; Navalta et al., 2018). For example, intense or constant stress endured by a developing brain exposed to adverse childhood experiences often results in physical and mental illness (Griffith, 2018). One meta-analysis found decreased hippocampal volume in adults who had experienced childhood maltreatment-related PTSD but not in children with maltreatment-related PTSD (Woon & Hedges, 2008), suggesting the hippocampal volume is affected over time, and early interventions may have the potential to address this change. In a random control treatment (RCT) pilot study, NFB produced significant reductions in PTSD symptoms, improved affect regulation, and had an effect size comparable to other evidence-based PTSD treatments (Gapen et al., 2016). In addition, a review of five studies examining the effect of NFB on PTSD suggested that NFB is probably efficacious for PTSD treatment (Reiter et al., 2016).

Substance Use Disorders

Understanding the full range of neural representations of substance use disorders (SUD) and appropriate neuro-informed interventions offers promising results (Hall & Walker, 2017). For instance, when transcendental meditation (TM) was compared with treatment-as-usual (TAU), involving an inpatient population with alcohol use disorder, there were no significant differences between the treatment groups. Individuals who practiced TM twice-daily, however, experienced lower levels of relapse, and regular TM practice was correlated with reduced stress, reduced craving, and less frequent alcohol use at follow-up (Gryczynski et al., 2018).

Peniston and Kulkosky (1989) provided brainwave training (BWT) protocol that included alpha and theta brainwave training, skin temperature biofeedback relaxation, and alcohol refusal imagery to people with alcohol addiction and found that, compared with controls, the BWT group had reductions in self-reported depression symptoms, physiological indicators of stress, and abstinence throughout 13 months of follow-up. This protocol was clinically evaluated with positive results in several studies (Sokhadze, 2016).

The Peniston BWT protocol was modified to treat psychostimulant disorders, known as the Scott-Kaiser modification (Sokhadze et al., 2014). In a study with 121 participants from a residential treatment program, the majority of whom were poly-drug users, NFB in addition to TAU was compared with TAU alone, and participants in the NFB plus TAU group stayed in treatment significantly longer, had greater abstinence rates at one year, and demonstrated significantly greater improvements on impulsivity and attention variables than those in the control group (Scott et al., 2005). In a review of the research of NFB for the treatment of SUD, Sokhadze et al. (2008) determined that NFB combined with residential treatment for alcohol use disorder, stimulant use disorders, and mixed substance use disorders is probably efficacious. Given the additive success of NFB in the treatment of a variety of SUDs, Sokhadze et al. (2014) recommended future NFB treatment for SUD be formally integrated with established behavioral interventions, such as CBT, motivational enhancement therapy, and maintenance medication.

Attention-Deficit/Hyperactivity Disorder

In a review of the efficacy literature on NFB and attention deficit/hyperactivity disorder (ADHD), Chapin and Russell-Chapin (2014) concluded that the strongest critics of NFB for ADHD treatment rated the intervention as "probably efficacious," while the strongest proponents found it "efficacious and specific" to ADHD. Van Doren et al. (2018) conducted a meta-analysis of 10 RTC studies among children with ADHD and found that within-group NFB effects on inattention were of medium effect size posttreatment but large effect size at follow-up.

Anxiety and Depression

In efficacy literature reviews for anxiety and depression, Chapin and Russell-Chapin (2014) reported that NFB for anxiety can be considered "probably efficacious" to "efficacious" and that NFB for depression can be considered "possibly efficacious." In a study targeting amygdala functioning in people with major depressive disorder, Young et al. (2014) found that participants who had undergone NFB training combined with positive autobiographical memory recall were able to regulate amygdala function and experienced improved mood. Similarly, a small study of Korean college students with depressive symptoms found NFB, combined with meditation, resulted in significant improvements after treatment and at four-month follow-up in both psychosocial flourishing and affect (Hwang et al., 2017). In their systematic review, Thabrew et al. (2018) identified nine studies, four of which were RTCs, that used different kinds of biofeedback, including heart rate variability (HRV), biofeedback-assisted relaxation therapy, and electroencephalography. This combination was effective in lessening anxiety, and HRV exercises reduced depression in two studies. Finally, in a multiphase mixed-methods pilot study examining use and perceptions of neuro-informed CBT (n-CBT), Field et al. (2016) found most counselors in the study believed n-CBT to be most effective in working with people with a range of anxiety and depressive disorders, and reductions in both anxiety and depression symptoms were reported.

Other Concerns

Neuro-informed counseling has been proposed for group counseling (Luke & Diambra, 2017), career counseling (Luke & Field, 2017), and working with athletes (Chapin, 2017). Biofeedback has been found to be effective in managing stress among individuals who must perform under stress for occupational success (Kennedy & Parker, 2018). From a wellness perspective, the incorporation of biofeedback and neurofeedback techniques may eventually show efficacy of a wide range of counseling approaches.

As the preceding review indicates, neurocounseling is a theory in the making and, thus, requires thoughtful development and rigorous evaluation. Continued research into the effectiveness of neuro-informed techniques is paramount.

The Millers

The following shows Jake in neurocounseling. After you read the vignette, answer the questions that follow. If you need to review background information about the Millers, go back to the end of Chapter 1.

Jake's Experience in Neurocounseling

Ever since Jake's children accidentally pushed his car out of park, and it moved down the driveway, Jake has been filled with anxiety and trying to control everything his family does, sometimes through angry outbursts. He also has difficulty sleeping and has nightmares about the accident he had with his sister, Justine, years ago. In addition, every day upon returning home from work and parking his car in the driveway, he has a panic attack. Jake has been struggling with anxiety his entire life, and despite having seen many therapists, it has not gotten any better. This time Jake decides to see a cognitive-behavioral therapist who integrates neuroscience into his work with clients.

Jake enters the office of Dr. Jim Oliver. The office looks very modern and is sparkling clean. Jake takes a seat in the waiting room, and before long, a tall man in a suit comes out. He extends his hand to Jake, and says, "I'm Dr. Oliver, glad to meet you. Why don't you come into my office?" His office is as clean and sparkling as the waiting room, and there are some unusual machines placed around the room. Dr. Oliver explains how he integrates neuroscience into his cognitive-behavioral therapy approach to counseling and describes the basic tenets of each approach. He goes on to note that he takes a wellness perspective with people and likes to obtain a good history from them, so he can assess those areas where they are stressed, as stress lessens the ability for neuroplasticity and change.

Dr. Oliver's first session is longer than the usual intake and lasts up to three hours. He first conducts a traditional intake with Jake, getting a thorough history, family background, and mental status. He then asks Jake to take the Therapeutic Lifestyle Change Inventory to assess those areas in his life where he is stressed and not attending to his own wellness. Next, he takes Jake on a visual journey, while he's hooked to an electroencephalogram (EEG). Here he attaches small electrodes (flat metal discs) to his scalp. The electrodes, which are attached to the EEG, measure brain wave signals. At first, he simply gets a baseline and finds that Jake is in the high alpha, low beta wave region. He then asks Jake to close his eyes and begin to visualize himself driving home and up his driveway. Quickly, Dr. Oliver sees that Jake's brainwaves switch into the high beta wave area, indicating anxiety and a fight and flight response. It is quickly clear that Jake's response to his visualization is reflective of his anxiety and is probably related to PTSD or a phobia.

Jake's anxiety, angry outbursts, and nightmares combined with insomnia and intrusive thoughts and images are most likely the result of his direct involvement with an acute traumatic event (the accident with Justine). These symptoms appear to be the result of the client's negative core beliefs of helplessness, regarding his inability to save his sister from injury during the accident. This negative core belief is serving as a foundation for his intermediate beliefs and resulting in cognitive distortions, which are manifesting themselves as the symptoms he is experiencing. The client's cognitive distortions include catastrophizing, should statements (e.g., Angela and the children "should" act in a certain way to avoid a problem), and overgeneralization about the possibility of something else horrible happening as a result of the car incident. Based on the constellation of symptoms, the time the client has been experiencing these symptoms, the fact that they began immediately following direct exposure to the original traumatic event, and the lack of any other evidence supporting an alternate diagnosis, this client's preliminary diagnosis of posttraumatic stress disorder and possible generalized anxiety disorder are possible.

During Jake's second session, Dr. Oliver says, "Well, based on my assessment of what you're going through, there are a number of areas I think we can work on. We can hopefully get you a bit of relief from all of the anxiety you have been struggling with."

"Boy, I hope so," answers Jake. "Honestly, my life has been hell lately."

"Let me tell you what I'm thinking," Dr. Oliver says. "Based on your history, it seems like you have some residual PTSD from the original accident with Justine, or at least a bit of a phobic reaction to certain situations, like when you come home from work and drive up your driveway. I also can

tell that, based on the responses to the Therapeutic Lifestyle Change Inventory, there are several areas that you are not attending to that are probably increasing stress in your life. And as we talked about during our last session, stress is the worst thing for making new neural connections and changing behaviors and feelings. So here's my proposal."

Dr. Oliver goes on to say that he would like to do the following:

1. Using CBT, focus on Jake's automatic thoughts and images and cognitive distortions and, eventually, his core beliefs.
2. Based on the Therapeutic Lifestyle Change Inventory, focus on three of his lowest scores: lack of positive thinking, lack of joy, and being too stressed (rarely feeling relaxed).
3. Teach neuroeducation and self-regulation techniques to help Jake learn to self-regulate his sympathetic and brain's stress reactions.
4. Conduct prolonged exposure (PE) therapy for his phobic reaction to driving up his driveway.
5. Use the EEG to assess changes in his phobic reaction and his overall state of being.

Dr. Oliver starts with CBT, and Jake quickly catches on. "It's amazing all of these 'automatic thoughts' I have that I never caught before," says Jake. "And I see how they're related to those cognitive distortions. I particularly catastrophize." Over time, Dr. Oliver hopes Jake will move toward understanding his intermediate beliefs and his core belief of helplessness, but for now, he seems to be making good progress and has been able to catch some of his negative automatic thoughts and images and even replace them with positive thoughts.

After consulting with Jake, based on the Therapeutic Lifestyle Change Inventory, Dr. Oliver and Jake jointly decide that Jake will take his kids out and do more playful things, such as going to the local mini golf course, the movies, and bowling. He also has begun an exercise regime to help reduce some of his stress.

Using newly learned neuroscience-based information and skills to self-regulate his physiological reaction, Jake and Dr. Oliver are ready to start PE. Here, Dr. Oliver has Jake make a hierarchical list of how anxious he feels at different points from his driveway. He is most anxious at the very top of his driveway and least anxious a block away. He then designs a system in which Jake will start with the lowest part of the anxiety (a block away) and sit there, in his car, for 30 minutes, twice a day. When he no longer feels anxiety (this might take a few days), he will go up to the next item on his hierarchy (e.g., a half block away). He will continue moving up the hierarchy, until he is at the top of the driveway. This will very likely take several days or, perhaps, even a few weeks. It is hoped that, over time, Jake's conditioned response to anxiety will be extinguished.

To assess changes over time, Dr. Oliver also has Jake hooked to the EEG every two or three weeks. There, he has him visualize the driveway and monitors his brainwaves. It is hoped that after a few weeks his brainwaves will remain in the low alpha wave range, indicating little anxiety.

After a few weeks pass, Jake is feeling a lot better. "I can't believe how much progress I've made in a short time," says Jake.

"This process took a while to develop," says Dr. Oliver, "and for you to fully recover, it will take some time."

Over the next few weeks, Dr. Oliver and Jake examine his intermediate and core beliefs, tackle more of the distressing areas identified on the Therapeutic Lifestyle Change Inventory, continue to practice self-regulation skills and PE, and assess his brainwaves through the EEG. Over time, Dr. Oliver hopes to show Jake how to move into theta and delta waves, indicating relaxation and deep meditation. He also hopes Jake will continue to practice behaviors that bring him more joy, positivity, and love in his life. Finally, Dr. Oliver hopes Jake can turn his core belief of helplessness into a belief that he can help himself and others.

For You to Consider

1. Do you believe a CBT approach is helpful with Jake?
2. Would you feel comfortable conducting a three-hour intake interview? Why, or why not?
3. Do you believe integrating neuroscience into Dr. Oliver's approach is worthwhile?
4. In what ways is neuroscience integrated into Dr. Oliver's approach?
5. In what ways is Dr. Oliver's approach wellness and strength-based?
6. Do you believe determining a diagnosis is congruent with a wellness approach to counseling?
7. Can you come up with any other cognitive distortions with which Jake might be struggling?
8. How would you feel using prolonged exposure therapy (PE)? How ethical is PE, since it causes Jake to initially feel more anxious?
9. How does using the Therapeutic Lifestyle Change Inventory, PE, and CBT relate to a neuroscience approach and neural pathway changes?
10. If you were working with Jake, what theoretical orientation do you believe would work best with him?
11. Would you consider integrating neuroscience techniques into your theoretical approach (from item 9)?
12. If you were in counseling, would you want neuroscience integrated into the approach that your counselor used? What techniques would you want them to use?

Summary

This chapter examined neurocounseling and began with its relatively brief history. It was noted that neurofeedback is a type of manipulation of physiology to increase mental health, such as progressive relaxation, started by Edmund Jacobson in the 1930s or biofeedback in the 1960s. Neurofeedback itself first became popular in the 1960s with studies by Joe Kamiya, who examined the kinds of training needed for a person to change brain wave activity.

Over the years, with advances in PET and MRI scans and the use of the EEG, there was an increased focus on measuring changes in the brain. Then, in 1998, Eric Kandel noted that counseling could change gene expression and alter neural networks. In the counseling profession, some of the early pioneers of neurocounseling included Lori Russell-Chapin, Allen Ivey, Mary Bradford Ivey, Carlos Zalaquett, and Chad Luke. Soon called one of the newest forces in counseling, this approach has taken on increased popularity in recent years as an approach that can be integrated into one's existing theoretical framework and as a standalone method.

The view of human nature for neurocounseling includes a wellness and strength-based approach that integrates neuroeducation. It is based on the fact that positive changes in one's environment and health can impact the structural biology of the brain through a process that stimulates neuroplasticity. Although many factors can positively change neural networks, some that were highlighted included physical exercise, sleep hygiene, gut-microbiomes, and lifestyle habits. It was also noted that significant brain changes occur over time. Thus, neurocounseling has a developmental focus because it is important for counselors to know potential changes in neural networks as people age.

A number of key concepts were discussed. For instance, we touched on the concept of neuroplasticity, which is the ability of the brain to alter its structure and function; neurogenesis, which is the ability of the brain to regrow damaged or lost neurons; and attention, arousal, and focus, which is related to how the brain changes as a function of one's ability to focus one's attention, such as when one is in counseling. We also delineated the parts of the limbic system, which is often called the seat of emotions and lies beneath the cerebral cortex. We highlighted the notion that there are major changes in brain functioning over one's lifespan; that mirror neurons are the mechanisms for a person to mimic the behaviors of others; that empathy can be observed by a client from a counselor and can be learned, neurologically, by mirror neurons; and that microskills have been found to change neural networks. Finally, this part of the chapter reviewed the function of different brainwaves (delta, theta, alpha, beta, and gamma brainwaves); how focusing on wellness and being positive can increase neuroplasticity; and that different types of therapy (e.g., DBT), and specific types of biofeedback and neurofeedback, can lead to self-regulation, which is important in relaxation, emotional stability, and an increase in neuroplasticity.

There are many neurocounseling techniques we explored in this chapter. For instance, we examined neuroeducation, which is teaching clients through didactic or experiential-based interventions the neurological basis for change (e.g., learning the hand model of the brain); the importance of assessing lifestyle by using self-assessments, such as the Therapeutic Lifestyle Changes Inventory, the indivisible self model, and the healthy mind platter; learning about self-regulation skills through biofeedback, especially how it relates to the sympathetic and parasympathetic systems (e.g., using diaphragmatic breathing, mindfulness, and technological approaches to biofeedback, such as heart rate variability [HRV] and lowering respiration rates); neurofeedback, which involves attaching electrodes to the scalp and measuring and training clients how to alter brainwaves; and using neuroscience-informed therapies, such as prolonged exposure therapy (PE) and eye desensitization movement reprocessing (EMDR).

A neuroscience-informed approach to counseling, it was noted, often starts with a general clinical assessment. This might include a traditional intake interview; use of assessments, such as the Therapeutic Lifestyle Changes Inventory, the indivisible self model, or the healthy mind platter; assessing brainwaves through an EEG; and applying appropriate developmental knowledge to the treatment plan. Neurocounseling can stand on its own if the counselor is trained in structural biology, or if the counselor obtains training through workshops and courses, it can be integrated into the counselor's existing approach.

Because the major focus of neurocounseling is identifying areas of stress within a person, it was noted that social justice issues, such as poverty, abuse, bullying, racism, sexism, heterosexism, discrimination, and other forms of oppression, can all negatively impact neural networks newborns and youngsters and negatively affect brain neurogenesis and plasticity in adults. Thus, we noted that neurocounselors must ensure they are attending to cultural sensitivities, religious and spiritual differences, intersecting identities, and various physical needs in their work with clients, as they build upon an existing theoretical framework, while incorporating neuro-informed elements. Advocacy for minorities, who are most likely to be the victims of social injustice, is thus critical for neurocounselors.

Relative to the efficacy of neurocounseling, we noted it has shown some benefit for the following populations: people affected by trauma, substance use disorders, attention-deficit/hyperactivity disorder, anxiety, and depression. We also noted it has been proposed for other types of counseling, such as group work, career counseling, and working with athletes. We concluded that neurocounseling is a theory in the making and, thus, requires thoughtful development and rigorous evaluation. Continued research into the effectiveness of neuro-informed techniques is paramount.

Key Words and Terms

adaptive information processing (AIP)
alpha waves
amygdala
arousal
assessment
attention
beta waves
biofeedback
body scan
brain dysregulation
brain-derived neurotrophic factors (BDNF)
brainwaves
cerebral cortex
cerebrum
client history and planning
closure
cortex
delta waves
desensitization
diaphragmatic breathing
EEG biofeedback
Electroencephalogram (EEG)
emotions
empathy
executive functioning
eye movement desensitization and reprocessing (EMDR)
fight or flight response
flip one's lid
focus
frontal cortex
functional magnetic resonance imaging (*f*MRI)
gamma waves
glial cells
glymphatic pathway
gut–microbiome–brain connection
hand model
healthy mind platter
hippocampus
hypothalamus
indivisible self model
installation
lifestyle
lifestyle assessment
lifestyle habits
limbic system
microskills
mindfulness
mirror neurons
myelin sheath
neurons
neural networks
neurocounselor
neuroeducation
neurofeedback (NFB)
neurogenesis
neuroplasticity
neuroscience-informed interventions
neuroscience-informed therapies
parasympathetic nervous system
positivity
positron emission tomography (PET)
prefrontal cortex
prefrontal lobotomies
preparation
prolonged exposure (PE) therapy
quantitative electroencephalogram (QEEG)
reevaluation
research domain criteria (RDoC)
reticular activating system
self-regulation
sleep hygiene
strength-based
structural biology
subjective units of disturbance (SUD) scale
sympathetic nervous system
Therapeutic Lifestyle Changes Inventory
theta waves
validity of cognition scale (VoC)
wellness

Key Names

Russell-Chapin, Lori
Ivey, Allen
Ivey, Mary Bradford
Jacobson, Edmund
Kamiya, Joe
Kandel, Eric
Luke, Chad
Zalaquett, Carlos

CREDITS

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Fig. 16.2: Source: https://lucymarymulholland.wordpress.com/2018/10/10/dr-daniel-siegels-hand-model-of-the-brain/.

References

Aarts, H., Custers, R., & Marien, H. (2008). Preparing and motivating behavior outside of awareness. *Science, 319,* 1639–1610. https://www.science.org/doi/10.1126/science.1150432

Abbass, A. A., Hancock, J. T., Henderson, J., & Kisely, S. (2006). Short-term psychodynamic psychotherapy for common mental health disorders. *The Cochrane Database of Systematic Review*, 4-CD004887.

Abrams, M., & Abrams, L. (2012). *A brief biography of Dr. Albert Ellis*. REBT.ws. http://www.rebt.ws/albertellisbiography.html

Abusaidi, E., Zahrakar, K., & Mohsenzadeh, F. (2018). Effectiveness of solution-focused brief couple therapy in improvement of communication patterns and marital intimacy in women. *Journal of Research and Health*, *8*(6), 555–564. https://doi.org/55.6.8.jrh/29252.1

Adler, A. (1927). *Understanding human nature*. Greenberg Publisher.

Adler, A. (1929). *The science of living*. Greenberg Publisher.

Adler, A. (1937). Mass psychology. *International Journal of Individual Psychology, 3,* 111–120.

Adler, A. (1958). *What life should mean to you*. (A. Porter, Ed.). G. Putnam. (Original work published in 1931)

Adler, A. (1963a). *The practice and theory of individual psychology.* (P. Radin, Trans.). Littlefield, Adams, & Co. (Original work published in 1925).

Adler, A. (1963b). *The problem child: The life style of the difficult child as analyzed in specific cases*. Capricorn. (Original work published 1930)

Adler, A. (1964a). Religion and individual psychology. In H. L. Ansbacher & R. R. Ansbacher (Eds.), *Superiority and social interest: A collection of later writings* (pp. 271–310). Northwestern University Press. (Original work published 1933)

Adler, A. (1964b). The structure of neurosis. In H. L. Ansbacher & R. R. Ansbacher (Eds.), *Superiority and social interest: A collection of later writings* (pp. 83–95). Northwestern University Press. (Original work published 1932)

Adler, A. (1964c). Advantages and disadvantages of the inferiority feeling. In H. L. Ansbacher & R. R. Ansbacher (Eds.), *Superiority and social interest: A collection of later writings* (pp. 50–58). Northwestern University Press. (Original work published 1933)

Adler, A. (1964d). Typology of meeting life problems. In H. L. Ansbacher & R. R. Ansbacher (Eds.), *Superiority and social interest: A collection of later writings* (pp. 66–70). Northwestern University Press. (Original work published 1935)

Adler, A. (1964e). Advantages and disadvantages of the inferiority feeling. In H. L. Ansbacher & R. R. Ansbacher (Eds.), *Superiority and social interest: A collection of later writings* (pp. 29–40). Northwestern University Press. (Original work published 1933)

Adler, A. (1966). The psychology of power. *Journal of Individual Psychology*, 22, 166–172. (Original work published 1928)

Adler, A. (1992). *What life could mean to you*. (P. Radin, Trans.). Oneworld. (Original work published 1931)

Adler, A. (2002a). Physician as educator (G. L. Liebenau, Trans.). In H. T. Stein (Ed.), *The collected clinical works of Alfred Adler* (Vol. 2, pp. 32–38). Alfred Adler Institute of Northwestern Washington. (Original work published 1904)

Adler, A. (2002b). A study of organ inferiority and its psychical compensation: A contribution to clinical medicine (G. L. Liebenau, Trans.). In H. T. Stein (Ed.), *The collected clinical works of Alfred Adler* (Vol. 2, pp. 115–222). Alfred Adler Institute of Northwestern Washington. (Original work published 1907)

Adler, A. (2002c). The neurotic character: Fundamentals of a comparative individual psychology and psychotherapy (C. Koen, Trans.). In H. T. Stein (Ed.), *The collected clinical works of Alfred Adler* (Vol. 1). Alfred Adler Institute of Northwestern Washington. (Original work published 1912)

Adler, A. (2005). Chapter II: Deficient social feeling, masculine protest: Woman 26 who wanted to be a man. In H. T. Stein (Ed.), *The collected works of Alfred Adler, Volume 9: Case histories: Problems of neurosis, The case of Mrs. A, the case of Miss R.* (pp. 20–30). The Classical Adlerian translation project. (Original work published 1929)

Agarwal, S. M., & Meany-Walen, K. (2019). Application of Adlerian play therapy with multiracial children. *International Journal of Play Therapy, 28(4),* 207–217. https://doi.org/10.1037/pla0000102

Aguayo, J. (2012). Freud, Jung, Sabina Spielrein and the countertransference: David Cronenberg's a dangerous method. *The International Journal of Psychoanalysis, 94*, 169–178. https://doi/org/10.1111/j.1745-8315.2012.00629.x

Akay, S., & Bratton, S. (2017) The effects of Adlerian play therapy on maladaptive perfectionism and anxiety in children: A single case design. *International Journal of Play Therapy*, *26*(2), 96–110. https://psycnet.apa.org/doi/10.1037/pla0000043

Alatiq, Y, & Alrshoud, H (2018). Family-based cognitive behavioural therapy for obsessive–compulsive disorder with family accommodation: Case report from Saudi Arabia. *The Cognitive Behaviour Therapist*, *11*(14), 1–13. https://doi.org/10.1017/S1754470X1800017X

Albert, L. (2003). *Cooperative discipline: A teacher's handbook*. American Guidance Service.
Aleksandrov, D. S., Bowen, A. R., & Colker, J. (2016). Parent training and cultural considerations. *The Journal of Individual Psychology, 72*(2), 77–89. https://doi.org/10.1353/jip.2016.0007
Allen, W., & Brickman, M. (1973). *Sleeper* [Original film script]. Rollins & Joffe Productions.
Al-Thani, A. S. (2012). *An Islamic modification of the person-centered counseling approach*. Bloomsbury Qatar Foundation Journals.
Alvarez-Buylla, A., & Lim, D. A. (2004). For the long run: Maintaining germinal niches in the adult brain, *Neuron, 42*, 683–686. http://dx.doi.org/10.1016/S0896-6273(04)00111-4
Alvy, K. T. (1994). *Parent training today*. Center of Improvement of Child Caring.
American Counseling Association. (2014). *Code of ethics*. http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=4
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).
American Psychological Association. (2014). *Think again: Men and women share cognitive skills: Research debunks myths about cognitive difference*. http://www.apa.org/action/resources/research-in-action/share.aspx
American Psychological Association (2017). *Ethical principles of psychologists and code of conduct*. https://www.apa.org/ethics/code
American Psychological Association. (2021). *APA guidelines on evidence-based psychological practice in health care*. https://www.apa.org/about/policy/psychological-practice-health-care.pdf
Amodeo, A. L., Picariello, S., Valerio, P., Bochicchio, V., & Scandurra, C. (2017). Group psychodynamic counselling with final-year undergraduates in clinical psychology: A clinical methodology to reinforce academic identity and psychological well-being. *Psychodynamic Practice, 23*(2), 161–180. https://doi.org/10.1080/14753634.2017.1308834
Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process, 26*, 415–428. https://doi.org/10.1111/j.1545-5300.1987.00415.x
Ansbacher, H. L. (1962). Was Adler a disciple of Freud? A reply. *Journal of Individual Psychology, 18*, 126–135.
Ansbacher, H. L. (1964). The increasing recognition of Adler. In H. L. Ansbacher & R. R. Ansbacher (Eds.), *Superiority and social interest: A collection of later writings* (pp. 3–19). Northwestern University Press.
Ansbacher, H. L., & Ansbacher, R. R. (Eds.). (1956). *The individual psychology of Alfred Adler: A systematic presentation in selections from his writings*. Basic Books.
Arain, M., Haque, M., Johal, L., Mathur, P., Nel, W., Rais, A., Sandhu, R., & Sharma, S. (2013). Maturation of the adolescent brain. *Neuropsychiatric Disease and Treatment, 9*, 449–460. https://doi.org/10.2147/NDT.S39776
Armour, R. (1953, February 16). A child's private logic. *Time Magazine, 63*.
A-Tjak, J. G. L., Davis, M. L., Morina, N., Powers, M. B., Smits, J. A. J., & Emmelkamp, P. M. G. (2015). A meta-analysis of the efficacy of acceptance and commitment therapy for clinically relevant mental and physical health problems. *Psychotherapy and Psychosomatics, 84*(1), 30–36. https://doi.org/10.1159/000365764
Avent Harris, J. R., Haskins, N., Parker, J., Lee, A. (2021). Womanist theology and relational cultural theory: Counseling religious Black women. *Journal of Creativity in Mental Health*, 1–19. https://doi.org/10.1080/15401383.2021.1999359
Aviv, R. (2005, August 19). The interpretation of dreams: Talking with Albert Ellis, world-renowned anti-Freud therapist. *The Village Voice*. http://www.villagevoice.com/arts/the-interpretation-of-reams-7137335
Bach, P., Hayes, S., & Gallop, R. (2012). Long-term effects of brief acceptance and commitment therapy for psychosis. *Behavior Modification, 36*(2), 165–181. https://doi.org/10.1177/0145445511427193
Bakic-Miric, N. (2008). Re-imaging understanding of intercultural communication, culture and culturing. *Journal of Intercultural Communications, 10*(17).
Bakker, G. (2008). *Practical CBT: Using functional analysis and standardized homework in everyday therapy*. Australian Academic Press.
Balart, P., & Oosterveen, M. (2019). Females show more sustained performance during test-taking than males. *Nature communications, 10*(1), 3798. https://doi.org/10.1038/s41467-019-11691-y
Ball, L. (2010). Profile of Carol Gilligan. In A. Rutherford (Ed.), *Psychology Feminist Voices Multimedia Internet Archive*. http://www.feministvoices.com/carol-gilligan/
Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological review, 84*(2), 191–215. https://psycnet.apa.org/doi/10.1037/0033-295X.84.2.191
Barekati, S., Bahmani, B., Noghiyaaee, M., Afrasiabi, M., & Marsa, R. (2017). The effectiveness of cognitive-existential group therapy on reducing existential anxiety in the elderly. *World Family Medicine/Middle East Journal of Family Medicine, 15*(8), 75–83. https://doi.org/10.5539/gjhs.v8n6p219
Barnes-Holmes, Y., Hussey, I., McEnteggart, C., Barnes-Holmes, D., & Foody, M. (2016). Scientific ambition: The relationship between relational frame theory and middle-level terms in acceptance and commitment therapy. In R. D. Zettle, S. C. Hayes, D. Barnes-Holmes, & A. Biglan (Eds.), *The Wiley handbook of contextual behavioral science* (pp. 365–382). Wiley.
Barratt, B. (1984). *Psychic reality and psychoanalytic knowing*. Analytic Press.
Barth, A. L., Barth, A. L., Moody, S. J., & Moody, S. J. (2019). Theory use in counseling practice: Current trends. *International Journal for the Advancement of Counselling, 41*(3), 313–328. https://doi.org/10.1007/s10447-018-9352-0
Bateman, A., & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *American Journal of psychiatry, 158*(1), 36–42. https://doi.org/10.1176/appi.ajp.158.1.36

Batten, S. V., & Ciarrochi, J. V. (2015). *Acceptance and commitment therapy.* In E. Neukrug (Ed.), The SAGE encyclopedia of theory in counseling and psychotherapy (Vol. 1, pp. 7–10). SAGE Publications.
Batthydiny, A., & Costello, S. J. (2015). *Viktor Frankl*. In E. S. Neukrug (Ed.). *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 321–434). SAGE Publications.
Bavelas, J., De Jong, P., Franklin, C. Froerer, A., Gingerich, W., Kim, J., Korman, H., Langer, S., Lee, M. Y., McCollum, E. E. Jordan, S. S., & Trepper, T. S. (2013). *Solution focused therapy treatment manual for working with individuals* (2nd ed.). Solution Focused Brief Therapy Association.
Beail, N. (2017). Psychodynamic psychotherapy. In J. Davies & C. Nagi (Eds.), *Individual psychological therapies in forensic settings* (pp. 142–156). Routledge.
Beaudoin, M. N., Moersch, M., & Evare, B. S. (2016). The effectiveness of narrative therapy with children's social and emotional skill development: an empirical study of 813 problem-solving stories. *Journal of Systemic Therapies*, *35*(3), 42–59. https://doi.org/10.1521/jsyt.2016.35.3.42
Beaulieu, T. (2010). Profile of Laura Brown. In A. Rutherford (Ed.), *Psychology Feminist Voices Multimedia Internet Archive.* https://feministvoices.com/profiles/carol-gilligan
Beck Institute. (2021a). *Dr. Beck*. https://beckinstitute.org/about/history-of-beck-institute/
Beck Institute. (2021b). *Dr. Aaron T. Beck: President emeritus*. https://beckinstitute.org/about/dr-aaron-beck/
Beck Institute. (2021c). *How CBT can help*. https://cares.beckinstitute.org/how-cbt-can-help/
Beck Institute. (2021d). About CBT. https://cares.beckinstitute.org/about-cbt/
Beck Institute. (2021e). *Research corner*. https://beckinstitute.org/resources-for-professionals/research-corner/
Beck Institute. (n.d.). *Recommended reading list for individuals*. https://cares.beckinstitute.org/wp-content/uploads/sites/2/2021/06/Recommended-Reading-for-Individuals.pdf
Beck, A. (2016). *Transcultural cognitive behavioural therapy for anxiety and depression: A practical guide*. Routledge.
Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. Harper and Row. Republished as *Depression: Causes and treatment*. University of Pennsylvania Press, 1972.
Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. International Universities Press.
Beck, A. T. (1991). Cognitive therapy: A 30-year retrospective. *American Psychologist*, *46*(4), 368–375. https://psycnet.apa.org/doi/10.1037/0003-066X.46.4.368
Beck, A. T. (1999). *Prisoners of hate: The cognitive basis of anger, hostility, and violence*. HarperCollins.
Beck, A. T. (2002). Prisoners of hate. *Behaviour Research and Therapy*, *40*(3), 209–216. https://psycnet.apa.org/doi/10.1016/S0005-7967(01)00103-6
Beck, A. T. (2005). The current state of cognitive therapy: A 40-year retrospective. *Archives of General Psychiatry*, *62*, 953–959. https://www.doi.org/10.1001/archpsyc.62.9.953
Beck, A. T., & Haigh, E. A. P. (2014). Advances in cognitive theory and therapy: The generic cognitive model. *Annual Review of Clinical Psychology*, *10*, 1–24. https://doi.org/10.1146/annurev-climpsy-032813-153734.
Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. Guilford Press.
Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *BDI-II Depression Inventory*. Psychological Corporation.
Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. Guilford Press.
Beck, J. S. (2005). *Cognitive therapy for challenging problems*. Guilford Press.
Beck, J. S. (2011). *Cognitive therapy for challenging problems* (2nd ed.). Guilford Press.
Beck, J. S. (2021). *Cognitive behavior therapy: Basics and beyond* (3rd ed.). Guilford Press.
Beck, J. S., & Busis, D. B. (2015). *The diet trap solution: Train your brain to lose weight and keep it off for good*. HarperCollins.
Beck, M. J., Lane, E., & Dodson, A. (2021). Using acceptance and commitment therapy to support a multi-tiered system of school counseling supports. *Journal of School Counseling*, *19*(31). http://www.jsc.montana.edu/articles/v19n31.pdf
Beels, C. C. (2009). Some historical conditions of narrative work. *Family process*, *48*, 363–373. https://doi.org/10.1111/j.1545-5300.2009.01288.x
Behavioral Tech. (2016a). *Peer-reviewed and published randomized controlled/comparative trials*. https://behavioraltech.org/wp-content/uploads/2018/04/RCT4ModesResearchDatatoDate2016.06.28-new-logo.pdf
Behavioral Tech. (2016b). *Research on dialectical behavior therapy: Summary of non-RCT studies*. https://behavioraltech.org/wp-content/uploads/2015/09/Non-RCTs-Research-Data-to-Date-2013.12-new-logo.pdf
Behavioral Tech. (2021a). *The reach of DBT*. https://behavioraltech.org/about-us/our-impact/
Behavioral Tech. (2021b). *Core evidence and research*. https://behavioraltech.org/research/evidence/
Bell, D. (1995). Who's afraid of critical race theory? *University of Illinois Law Review*, 4, 893–910.
Bennet, E. A. (1961). *C. G. Jung*. Barrie and Rockliff.
Bennett, R., & Oliver, J. (2019). *Acceptance and commitment therapy: 100 key points and techniques*. Routledge.
Benson, H., & Proctor, W. (2010). *Relaxation revolution*. Scribner.
Benveniste, H., Lee, H., & Volkow, N. D. (2017). The glymphatic pathway: Waste removal from the CNS via cerebrospinal fluid transport. *The Neuroscientist*, *23*(5), 454–465. https://doi.org/10.1177/1073858417691030
Berg, I. K. (1994). *Family based services: A solution-focused approach*. W. W. Norton & Company.
Berg, I. K. (2007, January 21). Obituary. *Milwaukee Journal Sentinel*. https://www.legacy.com/us/obituaries/jsonline/name/insoo-berg-obituary?id=3142762
Berg, I. K. (n.d.a). *Insoo Kim Berg vita*. San Diego State University. https://www.sdstate.edu/sites/default/files/2018-06/insoo-kim-berg-vita.pdf

Berg, I. K. (n.d.b). *For students only*. San Diego State University. https://www.sdstate.edu/sites/default/files/2018-06/for_students_only.pdf
Berg, I. K., & Dolan, Y. M. (2001). *Tales of solutions: A collection of hope-inspiring stories*. W. W. Norton & Company.
Berg, I. K., & Reuss, N. (1998). *Solutions step-by-step: Substance abuse treatment manual*. W. W. Norton & Company.
Berg, I. K., & Steiner, T. (2003). *Children's solution work*. W. W. Norton & Company.
Berg, I. K., & Szabo, P. (2005). *Brief coaching for lasting solutions*. W. W. Norton & Company.
Bergstrom I., Seinfeld S., Arroyo-Palacios J., Slater M., & Sanchez-Vives M. V. (2014). Using music as a signal for biofeedback. *International Journal of Psychophysiology, 93*, 140–149. https://doi.org/10.1016/j.ijpsycho.2013.04.01
Bernal, G., Jiménez-Chafey, M., & Domenech Rodríguez, M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*(4), 361–368. https://doi.org/10.1037/a001640
Berry, K., Day, C., Mulligan, L.D., Seed, T., Degnan, A., & Edge, D. (2018). Culturally adapted family intervention (CaFI): Case examples from therapists' perspectives. *The Cognitive Behaviour Therapist, 11(13)*, 1–18. https://doi.org/10.1017/S1754470X18000156
Besley, A. C. T., & Edwards, R. G. (2005). Editorial: Poststructuralism and the impact of the work of Michel Foucault in counselling and guidance. *British Journal of Guidance & Counselling, 33*(3), 277–281. https://doi.org/10.1080/03069880500179244
Bibbee, R. (2006). *The differential equation: Generation of the bi-cameral mind*. Software Research Books.
Binensztok, V., Vastardis, T. E., & Gill, C. S. (2018). Spiritual and religious interventions in "third wave" cognitive-behavioral therapies. In C. S. Gill & R. R. Freund (Eds.), *Spirituality and religion in counseling* (pp. 132–146). Routledge.
Binswanger, L. (1963). *Being-in-the-world: Selected papers of Ludwig Binswanger*. Basic Books.
Bishop, A. (2015). Freudian psychoanalysis. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 436–441). SAGE Publications.
Bishop, P. (2014). *Carl Jung*. Reaktion Books.
Black, D. (2006). *Psychoanalysis and religion in the 21st century: Competitors or collaborators*. Routledge.
Blackledge, J. T., & Drake, C. E. (2013). Acceptance and commitment therapy: Empirical and theoretical considerations. In S. Dymond & B. Roche (Eds.), *Advances in relational frame theory: Research & application* (pp. 219–252). New Harbinger Publications.
Bliss, T. V. P., & Cooke, S. F. (2011). Long-term potentiation and long-term depression: A clinical perspective. *Clinics, 66*(S1), 3–17. https://doi.org/10.1590/S1807-59322011001300002
Bluett, E. J., Homan, K. J., Morrison, K. L., Levin, M. E., & Twohig, M. P. (2014). Acceptance and commitment therapy for anxiety and OCD spectrum disorders: An empirical review. *Journal of Anxiety Disorders, 28*(6), 612–624. https://doi.org/10.1016/j.janxdis.2014.06.008
Brown, C. (2007). Situating knowledge and power in the therapeutic alliance. In C. Brown & T. Augusta-Scott (Eds.), *Narrative therapy: Making meaning, making lives* (pp. 3–22). SAGE Publications.
Bohecker, L., Lamantia, K., & Wagner, H. H. (2021). *Women theorists of psychotherapy and counseling*. Lexington Books.
Bottome, P. (1957). *Alfred Adler: A portrait from life*. The Vanguard Press.
Bowman, C. (2012). Reconsidering holism in gestalt therapy: A bridge to far. In T. B. Levine (Ed.), *Gestalt therapy: Advances in theory and practice* (pp. 27–38). Routledge.
Breger, L. (2009). *A dream of undying fame: How Freud betrayed his mentor and invented psychoanalysis*. Basic Books.
Brenkman, J. (2004). Freud the modernist. In M. S. Micale (Ed.), *The mind of modernism: Medicine, psychology, and the cultural arts in Europe and America, 1880–1940* (pp. 172–196). Stanford University Press.
Bretherton, R. (2006). Can existential psychotherapy be good news? Reflections on existential psychotherapy from a Christian perspective. *Mental Health, Religion & Culture, 9*(3), 265–275. doi:10.1080/13694670600615490
Bridle, S., & Edelstein, A. (2000, Spring/Summer). Was ist "das Ich"? *EnlightNext Magazine, 17*, 126–129, 176–177.
Briggs, S., Netuveli, G., Gould, N., Gkaravella, A., Gluckman, N. S., Kangogyere, P., Farr, R., Goldblatt, M. J., & Lindner, R. The effectiveness of psychoanalytic/psychodynamic psychotherapy for reducing suicide attempts and self-harm: Systematic review and meta-analysis. *British Journal of Psychiatry, 214*(6), 320–328. https://doi.org/10.1192/bjp.2019.33
Brodksy, B. S., & Stanley, B. (2013). *The dialectical behavior therapy primer: How DBT can inform clinical practice*. Wiley.
Brown, L. S. (n.d.). *Feminist therapy: What is feminist therapy? Laura S. Brown, PhD*. http://www.drlaurabrown.com/feminist-therapy/
Brown, S. S., McGriff, K., & Speedlin, S. (2018). Using relational–cultural theory to negotiate relational rebuilding in survivors of intimate partner violence. *Journal of Creativity in Mental Health, 13*, 136–147. https://doi.org/10.1080/15401383.2017.1355289
Buber, M. (1958). *I and thou*. Scribner.
Buber, M. (1970). *I and thou* (W. Kaufman, Trans.) Scribner. (Original work published 1923)
Buchheimer, A. (1959). From group to "Gemeinschaft." In K. A. Adler & D. Deutsch (Eds.), *Essays in individual psychology: Contemporary applications of Alfred Adler's theories* (pp. 242–246). Grove Press.
Burnes, T. R., Singh, A. A., Harper, A. J., Harper, B., Maxon-Kann, W., Pickering, D. L., Moundas, S., Scofield, T. R., Roan, A., & Hosea, J. (2010). American Counseling Association competencies for counseling with transgender clients. *Journal of LGBT Issues in Counseling, 4*, 135–159. https://doi.org/10.1080/15538605.2010.524839

Burtle, V. (1985). Therapeutic anger in women. In Rosewater, L. B., & Walker, L. E. A. (Eds.), *Handbook of feminist therapy: Women's issues in psychotherapy* (pp. 71–79). Springer.
Butler, M. (1985). Guidelines for feminist therapy. In Rosewater, L. B., & Walker, L. E. A. (Eds.), *Handbook of feminist therapy: Women's issues in psychotherapy* (32–38). Springer.
Buscaglia, L. (1996). *Love: What life is all about*. Ballantine Books.
Byers, L. G., Bragg, J., & Munoz, R. (2020). Increasing diversity and oppression scale scores through relational cultural theory. *Journal of Teaching in Social Work*, *40*(1), 18–30. https://doi.org/10.1080/08841233.2019.1685625
Cacioppo, J., & Decety, J. (2009). What are the brain mechanisms on which psychological processes are based? *Perspectives on Psychological Science*, *4*, 10–18. https://psycnet.apa.org/doi/10.1111/j.1745-6924.2009.01094.x
Cadaret, M. C., & Speight, S. L. (2018). An exploratory study of attitudes toward psychological help seeking among African American men. *Journal of Black Psychology*, *44*(4), 347–370. https://doi.org/10.1177/0095798418774655
Cade, B. (2007). Springs, streams, and tributaries: A history of the brief, solution-focused approach. In T. S. Nelson & F. N. Thomas (Eds.), *Handbook of solution-focused brief therapy: Clinical applications* (pp. 25–64). Haworth Press.
Cain, D. J., Keenan, K., & Rubin, S. (2016). Introduction. In D. J. Cain (Ed.), *Humanistic psychotherapies: Handbook of research and practice* (2nd ed., pp. 3–54). American Psychological Association.
Campbell, J. A. (2018). Person centered theory and considerations for counseling practice and teaching. *Global Engagement and Transformation*, *2*(1). https://scholarworks.iu.edu/journals/index.php/joget/article/view/24394
Carey, B. (2006, January, 31). Judge orders psychologist reinstated to institute. *New York Times*. http://www.nytimes.com/2006/01/31/nyregion/31ellis.html?ex=1180756800&en=4f0c1198ea0d7b91&ei=5070
Carey, B. (2011, June 23). Expert on mental illness reveals her own fight. *The New York Times*. http://archive.nytimes.com/www.nytimes.com/2011/06/23/health/23lives.html
Carey, B. (2021, November 2). Dr. Aaron T. Beck, pioneer of cognitive therapy, is dead at 100. *The New York Times*, A, p. 19.
Carey, M., Walter, S., & Russell, S. (2009). The absent but implicit: A map to support therapeutic inquiry. *Family Process*, *48*, 319–331. https://doi.org/10.1111/j.1545-5300.2009.01285.x
Carkhuff, R. (1969). *Helping and human relations* (Vol. 2). Holt, Rinehart & Winston.
Carkhuff, R. & Benoit, D. M. (2019). *The art of helping* (10th ed.). HRD Press, Inc.
Carlisle, K., Levitt, D., & Neukrug, E. (in press). Mental health counselors' perceptions of ethical behaviors. *Counseling and Values*, *XX(X)*.
Carlson, J., Watts, R. E., & Maniacci, M. (2006). *Adlerian therapy: Theory and practice*. American Psychological Association.
Carpenter, D. (2015). Ethical considerations in working with religious clients. In B. J. Mistler, & P. Brownell (Eds.), *Global perspectives on research, theory, and practice: A decade of gestalt!* (pp. 67–76). Cambridge Scholars Publishing.
Carroll, L. (1918). *Alice's adventures in wonderland*. Lee and Shepard.
Carter, R. (1999). *Mapping the mind*. Universtity of California Press.
Casement, A. (2015). Jung, Carl Gustav. In E. Neukrug (Ed.). *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 592–593). SAGE Publications.
Cassidy, J., & Shafer, P. R. (Eds.). (2008). *Handbook of attachment. theory, research, and clinical applications*. Guilford.
Castaños-Cervantes, S (2019). Brief CBT group therapy for Mexican homeless girls. *The Cognitive Behaviour Therapist*, *12*(12), 1–21. https://doi.org/10.1017/S1754470X18000272
Centers for Disease Control and Prevention. (2022). *Early brain developmen and health*. https://www.cdc.gov/ncbddd/childdevelopment/early-brain-development.html
Çerkez, Y., Manyeruke, G., Oduwaye, O., & Shimave, S. (2018). Ethical issues in counseling: A trend analysis. *Quality and Quantity*, *52*, 223–233. https://doi.org/10.1007/s11135-017-0604-6
Chan, C. D., Frank, C. D., DeMeyer, M., Joshi, A., Vargas, E. A., & Silverio, N. (2021). Counseling older LGBTQ+ adults of color: Relational-Cultural Theory in practice. *The Professional Counselor*, *11*(3), 370–382. https://doi.org/ 10.15241/cdc.11.3.370
Chamberlain, S. (n.d.). *A tale of narrative therapy*. Massey University. http://www.massey.ac.nz/~alock/diploma-demo/175772/narrative/mod1web/3hour1.html
Chapin, T. J. (2017). Wellness and optimal performance. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-based clinical approaches* (pp. 133–146). American Counseling Association. https://doi.org/10.1002/9781119375487.ch8
Chapin, T. J., & Russell-Chapin, L. A. (2014). *Neurotherapy and neurofeedback: Brain-based treatment for psychological and behavioral problems*. Routledge.
Chapman, J., Jamil, R. T., & Fleisher, C. (2021). *Borderline personality disorder*. National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/books/NBK430883/
Chatters, S., Zalaquett, C. P., & Ivey, A. E. (2017). Neuroscience-informed counseling theory. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-based clinical approaches* (pp. 101–114). American Counseling Association. https://doi.org/10.1002/9781119375487.ch6
Cheng, H. L., Wang, C., McDermott, R. C., Kridel, M., & Rislin, J. L. (2018). Self-stigma, mental health literacy, and attitudes toward seeking psychological help. *Journal of Counseling & Development*, *96*, 64–74. https://doi.org/10.1002/jcad.12178
Cheng, P., & Merrick, E. (2017). Cultural adaptation of dialectical behavior therapy for a Chinese international student with eating disorder and depression. *Clinical Case Studies*, *16*(1), 42–57. https://doi.org/10.1177/1534650116668269
Cheung, C. W., & Jahn, S. A. (2017). Closing the acculturation gap: A solution-focused approach with East Asian American families. *The Family Journal*, *25*(2), 170–178. https://doi.org/10.1177/1066480717697686

Chimpén-López, C. A., Pacheco, M., Pretel-Luque, T., Bastón, R., & Chimpén-Sagrado, D. (2021). The couple's tree of life: Promoting and protecting relational identity. Family Process, 1–14. https://doi.org/10.1111/famp.12727
Choi, H. M., & Lee, S. H. (2014). The development and application of a narrative therapy program to promote adolescents mental health. *Journal of Arts Psychotherapy, 10*(2), 311–335. http://lps3.www.earticle.net.libproxy.kne.ac.kr/Article/A228282
Choi, I. H., Jang, M. J., & Lee, D. M. (2017). Development of narrative therapy group counseling program for prevention of adolescents' smartphone addiction. *Korean Society for Computer Games, 30*, 11–23. https://doi.org/10.22819/kscg.2017.30.1.002
Christensen, A., Dimidjian, S., & Martell, C. R. (2015). Integrative behavioral couple therapy. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical handbook of couple therapy* (5th ed., pp. 61–96). Guilford Press.
Ciarrochi, J. V., & Bailey, A. (2008). *A CBT practitioner's guide to ACT: How to bridge the gap between cognitive-behavioral therapy & acceptance & commitment therapy*. New Harbinger Publications.
Clandinin, D. J., Caine, V., & Lessard, S. (2018). *The relational ethics of narrative inquiry*. Routledge.
Clark, A. J. (2002). *Early recollections: Theory and practice in counseling and psychotherapy*. Brunner-Routledge.
Clarke, J. J. (1992). *In search of Jung*. Routledge.
Clarkson, P. (2013). *Gestalt counselling in action* (4th ed.). SAGE Publications.
Clarkson, P., & Mackewn, J. (1993). *Fritz Perls*. SAGE Publications.
Clearfield, M. W., & Niman, L. C. (2012). SES affects infant cognitive flexibility. *Infant Behavior & Development, 35*, 29–35. https://doi.org/10.1016/j.infbeh.2011.09.007
Cloud, J. (2006). Happiness isn't normal. *Time, 167*, 58–67.
Codrington, R. (2010). A family therapist's look into interpersonal neurobiology and the adolescent brain: An interview with Dr. Daniel Siegel. *Australian and New Zealand Journal of Family Therapy, 31*, 285–299. https://doi.org/10.1375/anft.31.3.28
Collingridge, G. L., Peineau, S., Howland, J. G., & Wang, Y. T. (2010). Long-term depression in the CNS. *Nature Reviews Neuroscience, 11*(459–473). https://doi.org/10.1038/nrn2867
Collura, T. F. (2014). *Technical foundations of neurofeedback*. Routledge.
Combs, G., & Freedman, J. (2012). Narrative, poststructuralism, and social justice: Current practice in narrative therapy. *The Counseling Psychologist, 40*, 1033–1060. https://doi.org/10.1177/0011000012460662
Combs, G., & Freedman, J. (2016). Narrative therapy's relational understanding of identity. *Family Process, 55*, 211–224. https://doi.org/10.1111/famp.12216
Comstock, D. L., Hammer, T. R., Strentzch, J., Cannon, K., Parsons, J., & Salazar, F., II. (2008). Relational–cultural theory: A framework for bridging relational, multicultural, and social justice competencies. *Journal of Counseling & Development, 86*, 279–287. https://doi.org/10.1002/j.1556-6678.2008.tb00510.x
Conyne, R. K. (2015). Gestalt group psychotherapy. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 452–456). SAGE Publications.
Cook, J. M., Biyanova, T., & Coyne, J. C. (2009). Influential psychotherapy figures, authors, and books: An Internet survey of over 2,000 psychotherapists. *Psychotherapy: Theory, Research, Practice, Training, 46*(1), 42–51. https://doi.org/10.1037/a0015152
Cooper, M. (2008). *Essential research findings in counseling and psychotherapy: The facts are friendly*. SAGE Publications.
Corbett, L., & Milton, M. (2011). Existential therapy: A useful approach to trauma? *Counseling Psychology Review, 26*(1), 62–74.
Corcoran, J. (2012). Review of outcomes with children and adolescents with externalizing behavior problems. In C. Franklin, T. S. Trepper, W. J. Ginerich, & E. McCollum (Eds.), *Solution-focused brief therapy* (pp. 121–129). Oxford University Press.
Corcoran, J., & Pillai, V. (2009). A review of the research on solution focused therapy. *British Journal of Social Work, 39*, 234–242.
Corey, G. (2018). *The art of integrative counseling* (4th ed.). Wiley.
Corey, G., Corey, M. S., & Corey, C. (2019). *Issues and ethics in the helping professions* (10th ed.). Cengage.
Cornelius-White, J. (2016). *Person-centered, approaches for counselors*. SAGE Publications.
Cortina, M. (2010). The future of psychodynamic therapy. *Psychiatry, 73*, 43–56. https://doi.org/10.1521/psyc.2010.73.1.43
Cosio, D., & Schafer, T. (2015). Implementing an acceptance and commitment therapy group protocol with veterans using VA's stepped care model of pain management. *Journal of Behavioral Medicine, 38*(6), 984–997. https://doi.org/10.1007/s10865-015-9647-0
Coto-Lesmes, R., Fernández-Rodríguez, C., & González-Fernández, S. (2020). Acceptance and Commitment Therapy in group format for anxiety and depression. A systematic review. *Journal of Affective Disorders, 263*, 107–120. https://doi.org/10.1016/j.jad.2019.11.154
Cottone, R. R. (2001). A social constructivism model of ethical decision making in counseling. *Journal of Counseling and Development, 79*, 39–45. https//doi.org/10.1002/j.1556-6676.2001.tb01941.x
Council for Counseling and Related Education Programs. (2016). *2016 CACREP standards*. https://www.cacrep.org/for-programs/2016-cacrep-standards/
Craig, M., Vos, J., Cooper, M., & Correia, E. (2016). Existential psychotherapies. In D. J. Cain, K. Keenan, & S. Rubin (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (2nd ed., pp. 283–316). American Psychological Association.
Cramer, P. (2006). *Protecting the self: Defense mechanism in action*. Guilford.
Crenshaw, K. W. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*, 1241–1299.

Crenshaw, K. W. (2015, September 24). Why intersectionality can't wait. *The Washington Post*. https://www.washingtonpost.com/news/in-theory/wp/2015/09/24/why-intersectionality-cant-wait/
Crenshaw, K. W. (2017). *On intersectionality: Essential writings*. The New Press.
Crocker, S. (2015). Spirituality, dialogue, and the phenomenological method. In B. J. Mistler, & P. Brownell (Eds.), *Global perspectives on research, theory, and practice: A decade of gestalt!* (pp. 278–282). Cambridge Scholars Publishing.
Crocker, S., & Philippson, P. (2005). Phenomenology, existentialism, and eastern thought in gestalt therapy. In A. L. Woldt & S. M. Toman (Eds.), *Gestalt therapy: History, theory, and practice* (pp. 65–80). SAGE Publications.
Crockett, J. E., Gill, D. L., Cashwell, T. H., & Myers, J. E. (2017). Integrating non-technological and technological peripheral biofeedback in counseling. *Journal of Mental Health Counseling*, *39*(2), 163–179. https://doi.org/10.17744/mehc.39.2.06
Crowell, S. E., Beauchaine, T. P., & Linehan, M. M. (2009). A biosocial developmental model of borderline personality: Elaborating and extending Linehan's theory. *Psychological Bulletin*, *135*(3), 495. https://doi.org/10.1037/a0015616
Crumb, L., & Haskins, N. (2017). An integrative approach: Relational cultural theory and cognitive behavior therapy in college counseling. *Journal of College Counseling, 20*, 263–277. https://doi.org/10.1002.jocc.12074
Cuijpers, P., Reijnders, M., & Huibers, M. J. H. (2019). The role of common factors in psychotherapy outcome. *Annual Review of Clinical Psychology, 15*, 207–231. https://doi.org/10.1146/annurev-clinpsy-050718-095424
Cutts, L. (2011). Integration in counselling psychology: To what purpose? *Counselling Psychology Review, 26(2)*, 38–48.
Dahl, J., & Lundgren, T. (2006). *Living beyond your pain: Using acceptance and commitment therapy to ease chronic pain*. New Harbinger Publications.
Danto, E. A. (2005). *Freud's free clinics: Psychoanalysis and social justice, 1918–1938*. Columbia University Press.
David, D. O., Cotet, C., Matu, S., Mogoaşe, C., & Ştefan, S. (2017). 50 years of rational-emotive and cognitive-behavior therapy: A systematic review and meta-analysis. *Journal of Clinical Psychology*, *74*(3), 304–318. https://doi.org/10.1002/jclp.22514
David, D. O., Matu, S. A., Podina, I. R., & Predatu, R. M. (2019b). Future research directions for REBT. In M. E. Bernard, & W. Dryden (Eds.), *Advances in REBT* (pp. 121–146). Springer.
David, D. O., Sucala, M., Cotest, C., Şoflau, R., & Valenaş, S. (2019a). Empirical research in REBT theory and practice. In M. E. Bernard, & W. Dryden (Eds.), *Advances in REBT* (pp. 101–119). Springer.
Davidson, R. J., & McEwen, B. S. (2012). Social influences on neuroplasticity: Stress and interventions to promote well-being. *Nature Neuroscience*, *15*(5), 689–695. https://doi.org/10.1038/nn.3093
Davies, A. (2005, July 21–27). Shrink raps. *TimeOut New York, 512* [Electronic version]. http://www.rebt.ws/recentarticles.html
de Maat, S., De Jonghe, F., Schoevers, R., & Dekker, J. (2009). The effectiveness of long-term psychoanalytic therapy: A systematic review of empirical studies. *Harvard Review of Psychiatry, 17*(1), 1–23. doi:10.1080/10673220902742476
De Jong, P., & Berg, I. K. (2013). *Interviewing for solutions* (4th ed.). Cengage.
de Shazer, S. (1982). *Patterns of brief family therapy: An ecosystemic approach*. Guilford Press.
de Shazer, S. (1985). *Keys to solutions in brief therapy.*: W. W. Norton & Company.
de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. W. W. Norton & Company.
de Shazer, S. (1991). *Putting difference to work*. W. W. Norton & Co. Inc.
de Shazer, S. (1994). *Words were originally magic*. W. W. Norton & Company.
de Shazer, S. (n.d.). *Steve de Shazer vita*. San Diego State University. https://www.sdstate.edu/sites/default/files/2018-06/vita.pdf
de Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I. K. (2021). *More than miracles: The state of the art of solution-focused brief therapy (2nd ed.)*. Hawthorn Press.
Deakin, E. K., Nunes, M. L. T. (2009). Effectiveness of child psychoanalytic psychotherapy in a clinical outpatient setting. *Journal of Child Psychotherapy, 35*(3), 290–301. https://doi.org/10.1080/00754170903244621
DeAngelis, T. (2015). In search of cultural competence. *Monitor, 46*, 64.
Decety, J., & Jackson, P. L. (2004). The functional architecture of human empathy. *Behavioral and Cognitive Neuroscience Reviews, 3*, 71–100. https://doi.org/10.1177/1534582304267187
Decety, J., & Jackson, P. L. (2006). A social–neuroscience perspective on empathy. *Current Directions in Psychological Science, 15*, 54–58. https://doi.org/10.1111/j.09637214.2006.00406.x
Delgadillo, J., & Gonzalez Salas Duhne, P. (2020). Targeted prescription of cognitive–behavioral therapy versus person-centered counseling for depression using a machine learning approach. *Journal of Consulting and Clinical Psychology, 88*(1), 14–24. https://doi.org/10.1037/ccp0000476
Deming, W. E. (1986). *Out of the crisis*. MIT Center for Advanced Engineering Study.
Denborough, D. (2001). An interview with Michael White. In D. Denborough (Ed.). *Family therapy: Exploring the field's past, present and possible futures* (pp. 119–126). Dulwich Centred Publications.
Denborough, D. (2009). Some reflections on the legacies of Michael White: An Australian perspective. *The Australian and New Zealand Journal of Family Therapy, 30*, 92–1008.
Denborough, D. (2014). *Retelling the stories of our lives: Everyday narrative therapy to draw inspiration and transform experience*. W. W. Norton & Company.
Deutsch, D. (1958). Didactic group discussions with mothers in a child guidance setting—A theoretical statement. *Group Psychotherapy, XI(1)*, 52–56.
Dewane, C. J. (2008). The ABCs of ACT: Acceptance and commitment therapy. *Social Work Today, 8*(5), 34. https://www.socialworktoday.com/archive/090208p36.shtml

Dewell, J. (2105). Solution-focused brief family therapy. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 2, pp. 943–936). SAGE Publications.
Diamond, S. A. (2021, January 3). Essential secrets of psychotherapy: What is the shadow? Understanding the "dark side of our psyche." *Psychology Today*. https://www.psychologytoday.com/blog/evil-deeds/201204/essential-secrets-psychotherapy-what-is-the-shadow
Dickerson, J. F., Lynch, F. L., Leo, M. C., DeBar, L. L., Pearson, J., & Clarke, G. N. (2018). Cost-effectiveness of cognitive-behavioral therapy for depressed youth declining antidepressants. *Pediatrics, 141*(2), 1–9. https://doi.org/10.1542/peds.2017-1969
DiGiuseppe, R. A., Doyle, K. A., Dryden, W., & Backx, W. (2014). *A practitioner's guide to rational emotive behavior therapy* (3rd ed.). Oxford University Press.
Dinkmeyer, D., & Dreikurs, R. (1963). *Encouraging children to learn: The encouragement process*. Prentice Hall.
Dinkmeyer, D., & Eckstein, D. (1996). *Leadership by encouragement*. Saint Lucie Press.
Dinkmeyer, D., & Sperry, L. (2000). *Counseling and psychotherapy: An integrated, individual psychology approach*. Merrill.
Dipre, K. A., & Luke, M. (2020). Relational cultural theory—Informed advising in counselor education. *The Professional Counselor, 10*(4), 517–531. https://doi.org/ 10.15241/kad.10.4.517
Dobkin, M. (2005, October 28). Behaviorists behaving badly: Does Albert Ellis—elderly sexologist and godfather of cognitive psychotherapy—really deserve to be banished form the Upper East Side institute that bears his name? *New York Magazine*. http://nymag.com/nymetro/news/people/features/14947/
Dobson, K. S. (2012). *Cognitive therapy*. American Psychological Association.
Dolan, Y. (2006). Steve de Shazer: In memoriam. *Journal of Marital and Family Therapy, 32*(1), 1–2.
Dolan, Y. (2007). Tribute to Insoo Kim Berg. *Journal of Marital and Family Therapy, 33*(2), 129–131.
Dolgoff, R., Harrington, D., & Loewenberg, F. M. (2012). *Ethical decisions for social work practice* (9th ed.). Brooks/Cole.
Dominitz, V. A. (2017). Gestalt therapy applied: A case study with an inpatient diagnosed with substance use and bipolar disorders. *Clinical Psychology and Psychotherapy, 24*, 36–47. https://doi.org/10.1002/cpp.2016
Douthit, K. Z., & Russotti, J. (2017). Biology of marginality: A neurophysiological exploration of the social and cultural foundations of psychological health. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-based clinical approaches* (pp. 45–60). American Counseling Association. https://doi.org/10.1002/9781119375487.ch3
Driessen, E., Cuijpers, P., de Maat, S. C., Abbass, A. A., de Jonghe, F., & Dekker, J. J. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis. *Clinical Psychology Review, 30*(1), 25–36. https://doi.org/10.1080/00754170903244621
Driessen, E., Smits, N., Dekker, J. J. M., Peen, J., Don, F. J., Kool, S., Westra, D., Hendriksen, M., Cuijprers, P., & Van, H. L. (2016). Differential efficacy of cognitive-behavioral therapy and psychodynamic therapy for major depression: A study of prescriptive factors. *Psychological Medicine, 46*(4), 731–744. https://doi.org/10.1017/S0033291715001853
Dry, A. M. (1961). *The psychology of Jung: A critical interpretation*. Wiley.
Dryden, W., & Neenan, M. (2003). *The REBT therapist's pocket companion*. Albert Ellis Institute.
Duffey, T., & Trepal, H. (2016). Relational–cultural theory: Introduction to the special section on relational–cultural theory. *Journal of Counseling and Development, 94*, 379–382. https://doi.org/10.1002/jcad.12095
Dulwich Centre for Narrative Therapy. (n.d.). *Research, evidence, and narrative practice*. Dulwich Centre. https://dulwichcentre.com.au/collection-evidence-for-the-effectiveness-of-narrative-therapy/
Duncan, B. L. (2014). On becoming a better therapist: Evidence-based practice one client at a time. In B. L. Duncan (Ed.), *The heart and soul of change* (2nd ed., pp. 147–173). American Psychological Association.
Dunkin, M. (2019). The greatest of these is love. *International Journal of Choice Theory and Reality Therapy, XXXVIII*(2), 28–32.
Duvall, J., & Young, K. (2009). Keeping faith: A conversation with Michael White. *Journal of Systemic Therapies, 28*, 1–18. https://doi.org/10.1521/jsyt.2009.28.1.1
Dworkin, M. (2005). *EMDR and the relational imperative: The therapeutic relationship in EMDR treatment*. Routledge.
Dziordz, W. (2019). Reality therapy/choice theory and religion. *International Journal of Choice Theory® and Reality Therapy, 38*(2), 16–20.
Ebadi, Z., Pasha, R., Hafezi, F., & Eftekhar, Z. (2020). Effectiveness of reality therapy based on choice theory on marital intimacy and satisfaction. *Journal of Midwifery and Reproductive Health, 8*(2), 2230–2239. https://doi.org/10.22038/jmrh.2020.46037.1559
Eckstein, D., & Kern, R. (2002). *Psychological fingerprints: Lifestyle assessments and interventions*. Kendall/Hunt Publishing.
Egan, G. & Reese, R. J. (2019). *The skilled helper: A problem management and opportunity-development approach to helping* (11th ed.). Cengage.
Egger, N., Konnopka, A., Beutel, M. E., Herpertz, S., Hiller, W., Hoyer, J., Salzer, S., Stangier, U., Strauss, B., Willutzki, U., Wiltink, J., Leichsenring, F., Leibing, E., & König, H. H. (2015). Short-term cost-effectiveness of psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder: Results from the SOPHO-NET trial. *Journal of Affective Disorders, 180*, 21–28. https://doi.org/10.1016/j.jad.2015.03.037
Ehlers, C. L., & Kupfer, D. J. (1997). Slow wave sleep: Do young adult men and women age differently? *Journal of Sleep Research, 6*(3), 211–15. https://doi.org/10.1046/j.1365-2869.1997.00041.x
Ekman, P. (2016). *Nonverbal messages: Cracking the code. My life's pursuit*. Paul Ekman Group.
Ekstrom, S. R. (1988). Jung's typology and DSM-III personality disorders: A comparison of two systems of classification. *Journal of Analytical Psychology, 33*(4), 329–344.
Ellenberger, H. F. (1970). *The discovery of the unconscious: The history and evolution of dynamic psychiatry*. Basic Books.

Elliott, R., Bohart, A. C., Watson, J. C., & Murphy, D. (2018). Therapist empathy and client outcome: An updated meta-analysis. *Psychotherapy*, *55*(4), 399–410. https://doi.org/10.1037/pst0000175
Ellis, A. (1948). A critique of the theoretical contributions of non-directive therapy. *Journal of Clinical Psychology*, *4*, 248–255. https://psycnet.apa.org/doi/10.1002/1097-4679(194807)4:3%3C248::AID-JCLP2270040308%3E3.0.CO;2-8
Ellis, A. (1950). An introduction to the principles of scientific psychoanalysis. *Genetic Psychology Monographs*, *41*, 147–212.
Ellis, A. (1951a). Neurosis and human growth. *Psychological Bulletin*, *48*(6), 542–544.
Ellis, A. (1951b). *The folklore of sex*. Charles Boni.
Ellis, A. (1954). *The American sexual tragedy*. Twayne Publishers.
Ellis, A. (1956). An operational reformulation of some basic principles of psychoanalysis. *Psychoanalytic Review*, *43*, 163–180.
Ellis, A. (1957). *How to live with a neurotic*. Crown Publishers.
Ellis, A. (1958). *Sex without guilt*. Lyle Stuart.
Ellis, A. (1962). *Reason and emotion in psychotherapy*. Lyle Stuart.
Ellis, A. (1973). *Humanistic psychotherapy: A rational–emotive approach*. Institute for Rational Living.
Ellis, A. (1989). Comments on my critics. In M. E. Bernard & R. DiGiuseppe (Eds.), *Inside rational–emotive therapy: A critical appraisal of the theory and therapy of Albert Ellis* (pp. 199–235). Academic Press.
Ellis, A. (1994). *The essence of rational emotive behavior therapy*. [Brochure]. The Albert Ellis Institute.
Ellis, A. (1996a). A social constructionist position for mental health counseling: A reply to Jeffrey T. Guterman. *Journal of Mental Health Counseling*, *18*, 16–28.
Ellis, A. (1996b). *Better, deeper, and more enduring brief therapy: The rational emotive behavior therapy approach*. Bruner/Mazel.
Ellis, A. (1998). How rational emotive behavior therapy belongs in the constructivist camp. In M. F. Hoyt (Ed.), *The handbook of constructive therapies: Innovative approaches from leading practitioners* (pp. 83–99). Jossey-Bass.
Ellis, A. (2000). Can rational emotive behavior therapy (REBT) be effectively used with people who have devout beliefs in god and religion? *Professional Psychology: Research and Practice*, *31*(1) 29–33. https://psycnet.apa.org/doi/10.1037/0735-7028.31.1.29
Ellis, A. (2004a). *Rational emotive behavior therapy*. Prometheus Books.
Ellis, A. (2004b). Why I (really) became a therapist. *Journal of Rational–Emotive Cognitive Behavior Therapy*, *22*(2), 73–77. https://doi.org/10.1002/jclp.20166
Ellis, A (2004c). *The road to tolerance: The philosophy of rational emotive behavior therapy*. Prometheus Books.
Ellis, A. Ellis, A. (2006). *The myth of self-esteem*. Prometheus Books.
Ellis, A., & Harper, R. A. (1975). *A new guide to rational living*. Wilshire.
Ellis, A., & MacLaren, C. (2005). *Rational emotive behavior therapy: A therapist's guide* (2nd ed.). Impact Publishers.
Ellis, D. J. (2015). Rational emotive behavior therapy. In E. S. Neukrug, T*he SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 2, pp. 848–843). SAGE Publications.
Ellsworth, L. (2007). *Choosing to heal: Using reality therapy in the treatment of sexually abused children*. Routledge.
El-Sayes J., Harasym D., Turco C. V., Locke M. B., & Nelson, A. J. (2018). Exercise-induced neuroplasticity: A mechanistic model and prospects for promoting plasticity. *The Neuroscientist*, *25*(1), 65–85. https://doi.org/10.1177%2F1073858418771538
EMDR Institute. (2020a). *Frequent questions*? http://www.emdr.com/frequent-questions/
EMDR Institute. (2020b). *What is EMDR*? http://www.emdr.com/what-is-emdr/
EMDR Institute. (2020c). *The efficacy of EMDR*. http://www.emdr.com/efficacy/
Enns, C. (2021). Golden angels, sharp females and alternative heroines in A Tale of Two Cities. *The Macksey Journal*, *2*, Article 128.
Enns, C. Z. (2003). Contemporary adaptations of traditional approaches to the counseling of women. In M. Kopala, & M. A. Keitel, (Eds.), *Handbook of counseling women*. (pp. 3–21). SAGE Publications.
Enns, C. Z. (1994). Archetypes and gender: Goddesses, warriors, and psychological health. *Journal of Counseling & Development*, *73*(2), 127–133. https://psycnet.apa.org/doi/10.1002/j.1556-6676.1994.tb01724.x
Epictetus. (1900). *Discourses of Epictetus*. (B. Long, Trans.). D. Appleton and Company. (Original work published around 100 AD)
Epston, D. (2008). Saying hullo again: Remembering Michael White. *Journal of Systemic Therapies*, *27*(3), 1–15. https://doi.org/10.1521/jsyt.2008.27.3.1
Epston, D. (2016). Re-imagining narrative therapy: A history for the future. *Journal of Systemic Therapies*, *35*(2), 79–87. https://doi.org/10.1521/jsyt.2016.35.1.79
Epston, D., & White, M. (1992). *Experience, contradiction, narrative, and imagination: Selected papers of David Epston and Michael White, 1989–1991*. Dulwich Centre Publications.
Ergüner-Tekinalp, B. (2017). The effectiveness of Adlerian-based encouragement group counseling with college students in Turkey. *The Journal of Individual Psychology*, *73*(1), 54–69. https://doi.org/10.1353/jip.2017.0004
Evans, C. (2020). Adlerian play therapy and trauma. *The Journal of Individual Psychology*, *76*(2), 218–228. https://psycnet.apa.org/doi/10.1353/jip.2020.0002
Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, *16*, 319–324. https://psycnet.apa.org/doi/10.1037/h0063633
Farber, B. A., Suzuki, J. Y., & Lynch, D. A. (2018). Positive regard and psychotherapy outcome: A meta-analytic review. *Psychotherapy*, *55*(4), 411–423. https://doi.org/10.1037/pst0000171

Farhadi, A., Salehin, S., Aghayan, S., Keramat, A., & Talebi, S. (2020). The effectiveness of reality therapy based on choice theory on marital intimacy and sexual satisfaction of newly married women. *Avicenna Journal of Nursing and Midwifery Care*, *28*(2), 83–92. https://doi.org/10.30699/ajnmc.28.2.83

Farooq, D. M., Jefferson, J. L., & Fleming, J. (2005). The effect of an Adlerian video-based parent education program on parent's perception of children's behavior: A study of African American parents. *Journal of Professional Counseling: Practice, Theory, & Research*, *33*, 21–34.

Farrell, I. C., & Gibbons, M. M. (2019). Using narrative therapy to assist college-age Latino immigrants. *Journal of College Counseling*, *22*, 83–96. https://doi.org/10.1002/jocc.12116

Fassino, S., Amianot, F., & Ferrero, A. (2008). Brief Adlerian psychodynamic psychotherapy: Theoretical issues and process indicators. *Panminerva Medicine*, *50*(2), 165–175.

Feist, J., Feist, G. J., & Roberts, T. (2020). *Theories of personality* (10th ed.). McGraw-Hill.

Felixson, H. (Producer), & Marton, E. (Director). (2002). *My name was Sabina Spielrein* [Film]. Folkets Bio.

Feminist Therapy Institute. (1999). *Feminist therapy code of ethics* (revised). http://chrysaliscounseling.org/feminist-therapy-ii.html

Ferguson, E. D. (2009). *Adlerian theory: An introduction*. Adler School of Professional Psychology.

Fernbacher, S., & Plummer, D. (2005). Cultural influences and considerations in Gestalt therapy. In A. L. Woldt & S. M. Toman (Eds.), *Gestalt therapy: History, theory, and practice* (pp. 117–132). SAGE Publications.

Fiebert, M. S. (1997). In and out of Freud's shadow: A chronology of Adler's relationship with Freud. *Individual Psychology*, *53*(3), 241–269.

Field, T. A., Beeson, E. T., & Jones, L. K. (2016). Neuroscience-informed cognitive-behavior therapy in clinical practice: A preliminary study. *Journal of Mental Health Counseling*, *38*(2), 139–154. https://doi.org/10.17744/mehc.38.2.05

Field, T. A., Jones, L. K., & Russell-Chapin, L. A. (Eds.). (2017). *Neurocounseling: Brain-based clinical approaches*. American Counseling Association.

Fiorillo, D., McLean, C., Pistorello, J., Hayes, S. C., & Follette, V. M. (2017). Evaluation of a web-based acceptance and commitment therapy program for women with trauma-related problems: A pilot study. *Journal of Contextual Behavioral Science*, *6*(1), 104–113. https://doi.org/10.1016/j.jcbs.2016.11.003

Fiske, H. (2007). Solution-focused training: The medium and the message. In T. S. Nelson & F. N. Thomas (Eds.), *Handbook of solution-focused brief therapy: Clinical applications* (pp. 317–342). Haworth Press.

Flores, C. A., & Sheely-Moore, A. I. (2020). Relational–cultural theory-based interventions with LGBTQ college students. *Journal of College Counseling*, *23*, 71–84. https://doi.org/10.1002/jocc.12150

Ford, J. D., & Blaustein, M. E. (2013). Systemic self-regulation: A framework for trauma-informed services in residential juvenile justice programs. *Journal of Family Violence*, *28*, 665–677. https://doi.10.1007/s10896-013-9538-5

Fox, E. (2004–2022). *An introduction to relational frame theory*. FoxyLearning. https://foxylearning.com/product/introduction-to-relational-frame-theory/

Frankl, V. E. (n.d.). *Viktor Frankl video archives: Why education is failing*. The Viktor Frankl Institute. https://viktorfranklamerica.com/vf-video-gallery/

Frankl, V. E. (1975). *The unconscious God: Psychotherapy and theology*. Simon & Schuster.

Frankl, V. E. (1997). *Viktor Frankl—Recollections: An autobiography* (J. Fabry & J. Fabry, Trans.). Insight Books.

Frankl, V. E. (2004). Yearly report, October 1942–October 1943. In E. Makarova, S. Makarov, & V. Kuperman (Eds.), *University over the abyss: The story behind 520 lectures and 2,430 lectures in KZ Theresienstadt 1942–1944* (2nd ed., pp. 249–252). Verba Publishers. (Original work published 1943)

Frankl, V. E. (2014). *Man's search for meaning*. Beacon Press. (Original work published 1946)

Frankl, V. E. (2019). *The doctor and the soul: From psychotherapy to logotherapy* (3rd ed.). Vintage Books. (Original work published 1946)

Franklin, C., & Hai, A. H. (2021). Solution-focused brief therapy for substance use: A review of the literature. *Health & Social Work*, *46*(2), 103–114. https://doi.org/10.1093/hsw/hlab002

Franklin, C., Trepper, T. S., Gingerich, W. J., & McCollum, E. E. (2012). *Solution-focused brief therapy: A handbook of evidence-based practice*. Oxford University Press.

Fraser, L. (2005, Summer). Therapy with transgender people across lifespan. *APA Division 44 Newsletter*, *21*(3), 14–18.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. W. W. Norton and Company.

Freire, E. S., Koller, S. H., Piason, A., & da Silva, R. B. (2005). Person-centered therapy with impoverished, maltreated, and neglected children and adolescents in Brazil. *Journal of Mental Health Counseling*, *27*(3), 225–237. https://doi.org/10.17744/mehc.27.3.6p6qm84wqkkxp2a5

Freud, A. (1966). *The ego and the mechanisms of defense*. International Universities Press. (Original work published 1936)

Freud, S. (1910). *The origin and development of psychoanalysis*. *American Journal of Psychology*, *21*(2), 181–218. https://doi.org/10.2307/1413001

Freud, S. (1950). *Totem and taboo: Some points of agreement between the mental lives of savages and neurotics*. (J. Strachey, Trans.). W. W. Norton. (Original work published 1913)

Freud, S. (1953). "The first dream," fragment of an analysis of a case of hysteria. In J. Strachey & A. Freud (Eds.), *Complete works of Freud* (Vol. 7). (Original work published 1905)

Freud, S. (1961a). *Beyond the pleasure principle*. (J. Strachey, Trans.). W. W. Norton. (Original work published 1920)

Freud, S. (1961b). *The future of an illusion*. (J. Strachey, Trans.). W. W. Norton. (Original work published 1927)

Freud, S. (1961c). *The ego and the id*. (J. Strachey, Trans.). W. W. Norton. (Original work published 1927)
Freud, S. (1973). *Introductory lectures on psychoanalysis*. (J. Strachey, Trans.). Pelican Books. (Original work published 1917)
Freud, S. (1976a). *The interpretation of dreams*. (J. Strachey, Trans.). Penguin Books. (Original work published 1899)
Freud, S. (1976b). *Three essays on the theory of sexuality* (J. Strachey, Trans.). Basic Books. (Original work published Freud, S. (1905)
Freud, S. (1976c). *Jokes and their relation to the unconscious* (J. Strachey, Trans.). Penguin Books. (Original work published 1905)
Freud, S. (1989). *The psychopathology of everyday life*. (J. Strachey, Trans.). W. W. Norton. (Original work published 1901)
Freud, S. (2005). *Civilization and its discontents*. (J. Strachey, Trans.). W. W. Norton. (Original work published 1930)
Freud, S., & Breuer, J. (1974). *3 studies in hysteria*. (J. Strachey, Trans.). Penguin Books. (Original work published 1895)
Frew, J. (2016). Gestalt therapy: Creatively adjusting in an increasingly diverse world. *Gestalt Review, 20*, 106–128. https://psycnet.apa.org/doi/10.5325/gestaltreview.20.2.0106
Frey, L. L. (2013). Relational-cultural therapy: Theory, research, and application to counseling competencies. *Professional Psychology Research and Practice, 44*(3), 177–185. https://psycnet.apa.org/doi/10.1037/a0033121
Fuertes, J. N., & Nutt Williams, E. (2017). Client-focused psychotherapy research. *Journal of Counseling Psychology*, *64*(4), 369–375. https://doi.org/10.1037/cou0000214
Fulkerson, M. H. (2015). *Treatment planning from a reality therapy perspective*. iUniverse.
Fung, K. (2014). Acceptance and commitment therapy: Western adoption of Buddhist tenets? *Transcultural Psychiatry, 52*(4), 561–576. https://doi.org/10.1177%2F1363461514537544
Furtmuller, C. (1964). Alfred Adler: A biographical essay. In H. L. Ansbacher & R. R. Ansbacher (Eds.), *Superiority and social interest: A collection of later writings* (pp. 311–393). Northwestern University Press.
Gabrinetti, P. A. (2015). Analytical psychology. In E. Neukrug (Ed.), *The SAGE encyclopedia of counseling and psychotherapy* (Vol. 1, pp. 43–48). SAGE Publications.
Gading, I. K. (2020). Group counseling with the Gestalt technique to reduce academic procrastination. *iJET, 15*(14), 262–268. https://doi.org/10.3991/ijet.v15i14.14465
Gaffney, S. (2006). Gestalt with groups: A cross-cultural perspective. *Gestalt Review, 10*(3), 205–219. https://doi.org/10.5325/gestaltreview.10.3.0205
Ganley, C., & Lubienski, S. (2016). *Current research on gender differences in math*. National Council of Teachers of Mathematics. http://www.nctm.org/Publications/Teaching-Children-Mathematics/Blog/Current-Research-on-Gender-Differences-in-Math/
Gapen, M., van der Kolk, B. A., Hamlin, E., Hirshberg, L., Suvak, M., & Spinazzola, J. (2016). A pilot study of neurofeedback for chronic PTSD. *Applied Psychophysiology and Biofeedback*, *41*(3), 251–261. https://doi.org/10.1007/s10484-015-9326-5
Gaudiano, B. A., & Herbert, J. D. (2006). Acute treatment of inpatients with psychotic symptoms using acceptance and commitment therapy: Pilot results. *Behaviour Research and Therapy, 44*(3), 415–437. https://psycnet.apa.org/doi/10.1016/j.brat.2005.02.007
Gay, P. (2006). *Freud: A life for our time*. W. W. Norton.
Gaztambide, D. J. (2019). *A people's history of psychoanalysis: From Freud to liberation psychology*. Lexington Books.
Gelso, C. J., Kivlighan, D. M., Jr., & Markin, R. D. (2019). The real relationship. In J. C. Norcross & M. J. Lambert (Eds.), *Psychotherapy relationships that work: Evidence-based therapist contributions* (pp. 351–378). Oxford University Press. https://doi.org/10.1093/med-psych/9780190843953.003.0010
Genero, P., Miller, J., Surrey, J., & Baldwin, L. M. (1992). Measuring perceived mutuality in close relationships: Validation of the Mutual Psychological Development Questionnaire. *Journal of Family Psychology, 6*, 36–48. https://psycnet.apa.org/doi/10.1037/0893-3200.6.1.36
George, E., Iveson, C., & Ratner, H. (2015). Solution-focused brief therapy. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 2, pp. 946–950). SAGE Publications.
Gergen, K. (2015). *An invitation to social construction* (3rd ed.). SAGE Publications.
Gerhart, D. R. (2016). *Case documentation in counseling and psychotherapy: A theory-informed competency-based approach*. Cengage.
Ghavibazou, E., Hosseinian, S., & Abdollahi, A. (2020). Effectiveness of narrative therapy on communication patterns for women experiencing low marital satisfaction. *Australian and New Zealand Journal of Family Therapy, 41*(2), 195–207. https://doi.org/10.1002/anzf.1405
Ghorbani, R., & Raeisi, Z. (2020). The effect of narrative therapy on school anxiety in female primary students. *Quarterly Journal of Child Mental Health*, *6*(4), 168–178. http://dx.doi.org/10.29252/jcmh.6.4.16
Gilhooley, D. (2002). Misrepresentation and misreading in the case of Anna O. *Modern Psychoanalysis, 27*(1), 75–100.
Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Harvard University Press.
Gingerich, W. J., & Eisengart, S. (2000). Solution-focused brief therapy: A review of the outcome research. *Family process*, *39*(4), 477–498. https://psycnet.apa.org/doi/10.1111/j.1545-5300.2000.39408.x
Gingerich, W. J., & Peterson, L. T. (2013). Effectiveness of solution-focused brief therapy: A systematic qualitative review of controlled outcome studies. *Research on Social Work Practice, 23*(3), 266–283. https://doi.org/10.1177/1049731512470859
Ginsburg, G. S., & Drake, K. L. (2002). School-based treatment for anxious African Americans adolescents: A controlled pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(1), 768–775. https://doi.org/10.1097/00004583-200207000-00007

Gladding, S. T. (2017). *Counseling: A comprehensive profession* (8th ed.). Merrill.
Glasser Institute for Choice Theory. (n.d.). *Dr. William Glasser*. https://wglasser.com/about/dr-william-glasser/
Glasser, W. (1960). *Mental health or mental illness: Psychiatry for practical action*. Harper & Row.
Glasser, W. (1965). *Reality therapy: A new approach to psychiatry*. Harper & Row.
Glasser, W. (1969). *Schools without failure*. Harper & Row.
Glasser, W. (1972). *The identity society*. Harper & Row.
Glasser, W. (1976). *Positive addiction*. Harper & Row.
Glasser, W. (1981). *Stations of the mind: New directions for reality therapy*. Harper & Row.
Glasser, W. (1984) *Control theory*. Harper & Row.
Glasser, W. (1986). *Control theory in the classroom*. Harper & Row.
Glasser, W. (1989). *Control theory in the practice of reality therapy: Case studies*. Harper & Row.
Glasser, W. (1998). *Choice theory: A new psychology of personal freedom*. HarperCollins.
Glasser, W. (2001). *Counseling with choice theory: The new reality therapy*. HarperCollins.
Glasser, W. (2003). *Warning: Psychiatry can be hazardous to your mental health*. HarperCollins.
Glasser, W. (2006). *Every student can succeed*. William Glasser, Inc.
Glasser, W. (2013). *Take charge of your life: How to get what you need with choice theory psychology*. iUniverse.
Glasser, W., & Glasser, C. (1999). *The language of choice theory*. HarperCollins.
Glasser, W., & Glasser, C. (2000). *Getting together and staying together*. HarperCollins.
Glasser, W., & Glasser, C. (2007). *Eights lessons for a happier marriage*. HarperCollins.
Gloster, A. T., Walder, N., Levin, M. E., Twohig, M. P., & Karekla, M. (2020). The empirical status of acceptance and commitment therapy: A review of meta-analyses, *Journal of Contextual Behavioral Science, 18*, 181–192. https://doi.org/10.1016/j.jcbs.2020.09.009
Gnilka, P. B., McLaulin, S. E., Ashby, J. S., & Allen, M. C. (2017). Coping resources as mediators of multidimensional perfectionism and burnout. *Consulting Psychology Journal: Practice and Research*, *69*(3), 209–222. https://doi.org/10.1037/cpb0000078
Gnilka, P., O'Hara, C., & Chang, C. Y. (2023). Social advocacy. In D. G. Hays & B. T. Erford (Eds.), *Developing multicultural counseling competency: A systems approach* (4th ed). Pearson.
Gold, J. M. (2008). Rethinking client resistance: A narrative approach to integrating resistance into the relationship building stage of counseling. *Journal of Humanistic Counseling, Education, and Development, 47*(1), 65–70. https://www.doi.org/0.1002/j.2161-1939.2008.tb00047.x
Goldenberg, H., Stanton, M., & Goldenberg, I. (2016). *Family therapy: An overview* (9th ed.). Brooks/Cole.
Goleman, B. (2020). *Emotional intelligence: For a better life, success at work, and happier relationship* (2nd ed.). Brandon Goleman.
Golubic, M. (2013). *Lifestyle choices: Root causes of chronic diseases*. Cleveland Clinic. http://my.clevelandclinic.org/health/transcripts/1444_lifestyle-choices-root-causes-of-chronic-diseases
Gordon, D., & Meyers-Anderson, M. (1981). *Phoenix: Therapeutic patterns of Milton H. Erickson*. Meta Publications.
Göttken, T., White, L. O., Klein, A. M., & von Klitzing, K. (2014). Short-term psychoanalytic child therapy for anxious children: A pilot study. *Psychotherapy, 51*(1), 148–158. https://doi.org/10.1037/a0036026
Graham, M. A., Sauerheber, J. D., & Britzman, M. J. (2013). Choice theory and family counseling: A pragmatic, culturally sensitive approach. *The Family Journal, 21(2)*, 230–234. https://doi.org/10.1177/1066480712466538
Grande, T. L., Lightfoot, A., Davis, C., & Adair, E. (2017). Exploring treatments of childhood sexual abuse. *The Wisconsin Counseling Journal*, 54–65.
Grawe, K. (2007). *Neuropsychotherapy: How the neurosciences inform effective psychotherapy*. Psychology Press.
Griffith, J., & Powers, R. L. (2007). *The lexicon of Adlerian psychology: 106 terms associated with the individual psychology of Alfred Adler* (2nd ed.). Adlerian Psychology Associates.
Griffith, S. (2018). *The relationship between childhood adversity and adult relationship health for economically marginalized, racially and ethnically diverse individuals* [Doctoral dissertation, Old Dominion University].
Gross, A. C., & Fox, E. J. (2009). Relational frame theory: an overview of the controversy. *The Analysis of verbal behavior, 25*(1), 87–98. https://dx.doi.org/10.1007%2FBF03393073
Gross, S. (2000). Racism in the shadow of Jung. In E. Christopher & H. M. Solomon (Eds.), *Jungian thought in the modern world* (pp. 71–86). Free Association Books.
Gryczynski, J., Schwartz, R. P., Fishman, M. J., Nordeck, C. D., Grant, J., Nidich, S., Rothenberg, S., & O'Grady, K. E. (2018). Integration of Transcendental Meditation into alcohol use disorder (AUD) treatment. *Journal of Substance Abuse Treatment*, *87*, 23–30. https://doi.org/10.1016/j.jsat.2018.01.009
Guilfoyle, M. (2014). *The person in narrative therapy: A post-structural, Foucauldian account*. Palgrave Macmillan.
Guterman, J. T. (2013). *Mastering the art of solution-focused counseling* (2nd ed.). Wiley.
Guterman, J. T., & Rudes, J. (2008). Social constructionism and ethics: Implications for counseling. *Counseling and Values, 52*, 136–144. https/doi.org/10.1002/j.2161-007X.2008.tb00097.x
Haberstroh, S., & Moyer, M. (2012). Exploring an online self-injury support group: Perspectives from group members. *The Journal for Specialists in Group Work, 73*, 113–132. https://doi.org/10.1080/01933922.2011.646088

Hacker, T., Stone, P., & MacBeth, A. (2016). Acceptance and commitment therapy—Do we know enough? Cumulative and sequential meta-analyses of randomized controlled trials. *Journal of Affective Disorders, 190*, 551–565. https://doi.org/10.1016/j.jad.2015.10.053

Hackney, H. L., & Cormier, S. (2016). *The professional counselor: A process guide to helping* (8th ed.). Pearson.

Hafetz, D. (2005, October 9). Star shrink, 92, is psyched out. *New York Post*, 5.

Hagl, M., Powell, S., Rosner, R., &. Butollo, W. (2015). Dialogical exposure with traumatically bereaved Bosnian women: Findings from a controlled trial. *Clinical Psychology and Psychotherapy, 22*, 604–618. https://doi.org/10.1002/cpp.1921

Hahs, A., & Colic, M. (2010). 'Truth-making' in a world made up of stories. *Explorations: An E-Journal of Narrative Practice, 2*, 72–77. https://dulwichcentre.com.au/explorations-2010-2-adam-hahs-and-milan-colic.pdf

Hajhosseini, M. (2016). Effectiveness of group counseling based on reality therapy on academic procrastination and behavioral self-regulation of students. *International Journal of Behavioral Sciences, 10*(3), 119–124.

Halasz, G. (2004). Interview: In conversation with Dr. Albert Ellis. *Australasian Psychiatry, 12*(4), 325–333. https://doi.org/10.1080%2Fj.1440-1665.2004.02121.x

Hall, C. S., & Nordby, V. J. (1999). *A primer of Jungian psychology*. Meridian. (Original work published in 1973)

Hall, E. T. (1959). *The silent language*. Doubleday.

Hall, E. T. (1976). *Beyond culture*. Doubleday.

Hall, K. G., Barden, S., & Conley, A. (2014). A relational–cultural framework: Emphasizing relational dynamics and multicultural skill development. *The Professional Counselor, 4*, 71–83. https://doi.org/10.15241/kgh.4.1.71

Hall, S. B., & Walker, K. D. (2017). Clinical nseuroscience of substance use disorders. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-Based Clinical Approaches* (pp. 147–164). American Counseling Association. https://doi.org/10.1002/9781119375487

Handy, E. J. (2015). *A comprehensive enrichment program addressing academic achievement gap of African American males* [Master's thesis, Saint Mary's College of California]. ProQuest. https://www.proquest.com/openview/16271f7442777e338316e4c70d23aa20/1?pq-origsite=gscholar&cbl=18750

Hansen, J. T. (2010). Counseling and psychoanalysis: Advancing the value of diversity. *Journal of Multicultural Counseling and Development, 38*(1), 16–26.

Hansen, J. T., Speciale, M., & Lemberger, M. E. (2014). Humanism: The foundation and future of professional counseling. *The Journal of Humanistic Counseling, 53*, 170–190. https://doi.org/10.1002/j.2161-1939.2014.00055.

Harned, M., Korslund, K., & Linehan, M. (2014). A pilot randomized controlled trial of dialectical behavior therapy with and without the dialectical behavior therapy prolonged exposure protocol for suicidal and self-injuring women with borderline personality disorder and PTSD. *Behaviour Research and Therapy, 55*, 7–17. http://dx.doi.org/10.1016/j.brat.2014.01.008

Harned, M., Korslund, K., Foa, E., & Linehan, M. (2012). Treating PTSD in suicidal and self-injuring women with borderline personality disorder: Development and preliminary evaluation of a dialectical behavior therapy prolonged exposure protocol. *Behaviour Research and Therapy, 50*(6), 381–386. https://doi.org/10.1016/j.brat.2012.02.01

Harper, A., Finnerty, P., Martinez, M., Brace, A., Crethar, H. C., Loos, B., Harper, B., Graham, S., Singh, A., Kocet, M., Travis, L., Lambert, S. Burnes, T., Dickey, L. M., & Hammer, T. R. (2013). Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling competencies for counseling with lesbian, gay, bisexual, queer, questioning, intersex, and ally individuals. *Journal of LGBT Issues in Counseling, 7*(1), 2–43. https://doi.org/10.1080/15538605.2013.755444

Harris, R. (2006). Embracing your demons: An overview of acceptance and commitment therapy. *Psychotherapy in Australia, 12*(4), 2–8.

Harris, R. (2009). *ACT made simple: An easy-to-read primer on acceptance and commitment therapy*. New Harbinger Publications.

Harris, R. (2015). *Values vs. goals [Video]*. The Happiness Trap. https://thehappinesstrap.com/values-vs-goals/

Harrison, K. (2013). Counselling psychology and power: Considering therapy and beyond. *Counselling Psychology Review, 28*(2), 107–117.

Hart, B. (1995). Re-authoring the stories we work by: Situating the narrative approach in the presence of the family of therapists. *Australian and New Zealand Journal of Family Therapy, 16*(4), 181–189. https://psycnet.apa.org/doi/10.1002/j.1467-8438.1995.tb01058.x

Hart, J., Corriere, R., & Binder, J. (1975). *Going sane: An introduction to feeling therapy*. Jason Aronson.

Hartling, L. M. (2008). Jean Baker Miller: Living in connection. *Feminism and Psychology, 18(3)*, 332–335. https://doi.org/10.1177/0959353508092084

Haskins, N. H., & Appling, B. (2017). Relational–cultural theory and reality therapy: A culturally responsive integrative framework. *Journal of Counseling & Development, 95*(1), 87–99. https://doi.org/10.1002/jcad.12120

Haskins, N., & Singh, A. A. (2015). Critical race theory and counselor education pedagogy: Creating equitable training. *Counselor Education and Supervision, 54*, 288–301. https://doi.org/10.1002/ceas.12027

Havel, V. (1990). *Disturbing the peace: A conversation with Karel Hvizdala*. (P. Wilson, Trans.). Alfred. A. Knopf.

Hays, D. G., & Singh, A. A. (2023). *Qualitative research in education and social sciences* (2nd ed.). Cognella Academic Publishing.

Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35*(4), 639–665. https://doi.org/10.1016/S0005-7894(04)80013-3

Hayes, S. C. (2008). *Career influences and a brief intellectual autobiography*. Steven Chayes. http://www.stevenchayes.com/about/career-influences-and-a-brief-intellectual-autobiography/

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). Relational frame theory: A précis. In S. C. Hayes, D. Barnes-Holmes, & B. Roche (Eds.), *Relational frame theory: A post-Skinnerian account of human language and cognition* (pp. 141–154). Springer.
Hayes, S. C., & Brownstein, A. J. (1985). *Verbal behavior, equivalence classes, and rules: New definitions, data, and directions [Conference paper presentation].* Annual Meeting of the Association for Behavior Analysis, Columbus, OH, United States. https://contextualscience.org/publications/hayes_brownstein_1985
Hayes, S. C., & Hofmann, S. G. (2017). The third wave of cognitive-behavioral therapy and the rise of process-based care. *World Psychiatry, 16*(3), 245–246. https://doi.org/10.1002/wps.20442
Hayes, S. C., Levin, M. E., Plumb-Vilardaga, J., Villatte, J. L., & Pistorello, J. (2013). Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. *Behavior Therapy, 44*(2), 180–198. https://doi.org/10.1016/j.beth.2009.08.002
Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes, and outcomes. *Behaviour Research and Therapy, 44*(1), 1–25. https://doi.org/10.1016/j.brat.2005.06.006
Hayes, S. C., Masuda, A., Bissett, R., Luoma, J., & Guerrero, L. F. (2004a). DBT, FAP, and ACT: How empirically oriented are the new behavior therapy technologies? *Behavior Therapy, 35*(1), 35–54. https://doi.org/10.1016/S0005-7894(04)80003-0
Hayes, S. C., Pistorello, J., & Levin, M. E. (2012b). Acceptance and commitment therapy as a unified model of behavior change. *The Counseling Psychologist, 40*(7), 976–1002. https://psycnet.apa.org/doi/10.1177/0011000012460836
Hayes, S. C., Stroshal, K. D., Buntinh, K., Twohig, M., & Wilson, K. (2004b). What is acceptance and commitment therapy. In S. C. Hayes & K. D. Strosahl (Eds.), *A practical guide to acceptance and commitment therapy* (pp. 1–30). Springer.
Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012a). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). Guilford Press.
Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64*(6), 1152–1168. https://doi.org/10.1037/0022-006X.64.6.1152
Hayman, R. (2001). *A life of Jung*. W. W. Norton & Company.
Hays, D. G., & Gay, J. L. (2022). The culturally competent counselor. In D. G. Hays & B. T. Erford (Eds.), *Developing multicultural counseling competence: A systems approach* (4th ed.). Pearson.
Hays, D. G., & Gay, J. L. (2023). The culturally competent counselor. In D. G. Hays & B. T. Erford (Eds.), *Developing multicultural counseling competency: A systems approach* (4th ed). Pearson.
Hays, P. A. (2009). Integrating evidence-based practice, cognitive-behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice, 40*(4), 354– 360. https://psycnet.apa.org/doi/10.1037/a0016250
Hays, P. A. (2014). An international perspective on the adaptation of CBT across cultures. *Australian Psychologist, 49*, 17–18. https://doi.org/10.1111/ap.12027
Hays, P. A. (2019). Introduction. In P. A. Hays & G. W. Iwamasa (Eds.), *Culturally responsive cognitive–behavioral therapy: Practice and supervision* (2nd ed.). American Psychological Association.
Hedtke, L. (2016). Constructing matrilineal connections in a remembering conversation. In V. Dickerson (Ed.), *Poststructural and narrative thinking in family therapy* (pp. 45–60). Springer.
Heins, T., & Ritchie, K. (1988). *Beating sneaky poo: Ideas for faecal soiling* (2nd ed.). https://dulwichcentre.com.au/beating-sneaky-poo-2.pdf
Heller, L., & Sweet, J. (Producers), & Ginsberg, A. (Director). (2003). *The iceman and the psychiatrist* [TV movie]. HBO.
Hender, K. (2001). *Is gestalt therapy more effective than other therapeutic approaches?* Center for Clinical Effectiveness. http://www.eagt.org/research/poland/Gestalt%20therapy%20effectiveness%20comparisons%20(2).pdf
Hesser, H., Gustafsson, T., Lundén, C., Henrikson, O., Fattahi, K., Johnsson, E., Westin, V. Z., Calbring, P., Mäki-Torkko, E., Kaldo, V. & Andersson, G. (2012). A randomized controlled trial of internet-delivered cognitive behavior therapy and acceptance and commitment therapy in the treatment of tinnitus. *Journal of Consulting and Clinical Psychology, 80*(4), 649–661. https://psycnet.apa.org/doi/10.1037/a0027021
Hilbon, R. C. (2000). *Chaos and nonlinear dynamics: An introduction for scientists and engineers* (2nd ed.). Oxford University Press.
Hill, A. L. (2004). Ethical analysis in counseling: A case for narrative ethics, moral visions, and virtue ethics. *Counseling & Values, 48*(2), 131–148. htpps://doi:10.1002/j.2161-007X.2004.tb00240.x
Hilsenroth, M. (Ed.). (2014). Common factors [Special section]. *Psychotherapy, 51*, 467–524.
Hirano, Y., Oribe, N., Kanba, S., Onitsuka, T., Nestor, P. G., & Spencer, K. M. (2015). Spontaneous gamma activitiy in schizophrenia. *JAMA Psychiatry, 72*(8), 813–821. http://dx.doi.org/10.1001/jamapsychiatry.2014.2642
Hocoy, D. (2019). The challenge of multiculturalism in humanistic psychology. In L. Hoffman, H. Cleare-Hoffman, N. Granger, & D. St. John (Eds.), *Humanistic approaches to multiculturalism and diversity* (pp. 18–28). Routledge.
Hoffler, A. (2001). Jung's analysis of Sabina Spielrein and his use of Freud's free association method. *Journal of Analytical Psychology, 46*, 117–128. https://doi.org/10.1111/1465-5922.00218
Hoffman, E. (1994). *The drive for self: Alfred Adler and the founding of individual psychology*. Addison-Wesley.
Hoffman, L. (2018). Existential guilt. *Encyclopedia of psychology and religion*. https://doi.org/10.1007/978-3-642-27771-9_200194-1
Hoffman, L. (2021). Existential–humanistic therapy and disaster response: Lessons from the COVID-19 pandemic. *Journal of Humanistic Psychology, 61*, 33–54. https://doi.org/10.1177/0022167820931987

Hoffman, L., & Cleare-Hoffman, H. P. (2011). Existential therapy and emotions: Lessons from cross-cultural exchange. *Humanistic Psychologist*, *39*(3), 261–267. https://doi.org/10.1080/08873267.2011.594342

Hoffman, L., Vallejos, L., Cleare-Hoffman, H. P., & Rubin, S. (2015). Emotion, relationship, and meaning as core existential practice: Evidence-based foundations. *Journal of Contemporary Psychotherapy*, *45*(1), 11–20. https:/doi.org/10.1007/s10879-014-9277-9

Hofman, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, M. A., & Fang, A., (2012). The efficacy of cognitive-behavioral therapy: A review of meta-analyses. *Cognitive Therapy Research*, *36*(5), 427–440. https://doi/org/10.1007/s10608-012-9476-1

Holowchak, M. S. (2012). Freud's Oedipus complex: Shibboleth or canard? In M. S. Holowchak (Ed.) *Radical claims in Freudian psychoanalysis: Point/counterpoint* (pp. 3–26). Jason Aronson.

Holyoake, D-D., & Golding, E. (2012). Multiculturalism and solution-focused psychotherapy: An exploration of the nonexpert role. *Asia Pacific Journal of Counseling and Psychotherapy*, *3*, 72–81. https://doi.org/10.1080/21507686.2011.651479.

Hopcke, R. H. (1999). *A guided tour of the collected works of C. G. Jung*. Shambhala Publications.

Hopkins, J. (2015). Sigmund Freud. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 434–436). SAGE Publications.

Housby, H., Thackeray, L., & Midgley, N. (2021). What contributes to good outcomes? The perspective of young people on short-term psychoanalytic psychotherapy for depressed adolescents. *PLoS One*, *16*(9). https://doi.org/10.1371/journal.pone.0257334

Hoyt, M. F. (1996). Solution building and language games: A conversation with Steve de Shazer. In M. F. Hoyt (Ed.), *Constructive therapies* (Vol. 2, pp. 60–86). Guilford Press.

Hsu, K. S., Eads, R., Lee, M. Y., & Wen, Z. (2021). Solution-focused brief therapy for behavior problems in children and adolescents: A meta-analysis of treatment effectiveness and family involvement. *Children and Youth Services Review*, *120*, Article 105620. https://doi.org/10.1016/j.childyouth.2020.105620

Hulbert-Williams, N. J., Storey, L., & Wilson, K. G. (2015). Psychological interventions for patients with cancer: Psychological flexibility and the potential utility of acceptance and commitment therapy. *European Journal of Cancer Care*, *24*(1), 15–27. https://doi.org/10.1111/ecc.12223

Hurley, D. (2004, May 4). Scientist at work: Albert Ellis. From therapy's Lenny Bruce: Get over it! Stop whining! *New York Times*: *Health Section*. [Electronic version]. http://www.nytimes.com/2004/05/04/health/psychology/04PROF.html?pagewanted=2&ei=5070&en=7f9ae346ae424997&ex=1180670400

Hwang, K., Kwon, A., & Hong, C. (2017). A preliminary study of new positive psychology interventions: Neurofeedback-aided meditation therapy and modified positive psychotherapy. *Current Psychology*, *36*(3), 683–695. https://doi.org/10.1007/s12144-016-9538-8

Hyland, P., & Boduszek, D. (2012). Resolving a difference between cognitive therapy and rational emotive behaviour therapy: Towards the development of an integrated CBT model of psychopathology. *Mental Health Review Journal*, *12*(2), 104–116. http://dx.doi.org/10.1108/13619321211270425

Hyland, P., Shelvin, M., Adamson, G., & Boduszek, D. (2014). The moderating role of rational beliefs in the relationships between irrational beliefs and posttraumatic stress symptomology. *Behavioural and Cognitive Psychotherapy*, *42*(3), 312–326. https://doi.org/10.1017/S1352465813000064

Ime, Y. (2019). Solution-focused brief therapy and spirituality. *Spiritual Psychology and Counseling*, *4*, 143–161. https://doi.org/10.12738/spc.2019.4.2.0065

Ingersoll, R. E., & O'Neill, B. (2005). Gestalt therapy and spirituality. In A. L. Woldt & S. M. Toman (Eds.), *Gestalt therapy: History, theory, and practice* (pp. 133–150). SAGE Publications.

Insel, T (2013, April 29). *Transforming diagnosis*. National Institute of Mental Health. http://psychrights.org/2013/130429NIMHTransformingDiagnosis.htm

Institute for Solution-Focused Therapy. (2022). *What does the research say about solution-focused brief therapy*? https://solutionfocused.net/research-in-solution-focused-therapy/

International Conference on Research in Gestalt Therapy. (n.d.). https://research-conference-hamburg2021.com/datenschutzerklaerung/

Ivanova, E., Jensen, D., Cassoff, J., Gu, F., & Knäuper, B. (2015). Acceptance and commitment therapy improves exercise tolerance in sedentary women. *Medicine & Science in Sports & Exercise*, *47*(6), 1251–1258. https://doi.org/10.1249/MSS.0000000000000536

Iveson, S. (2005, October 12). Steve de Shazer. *The Guardian*. https://www.theguardian.com/news/2005/oct/13/obituaries.mainsection

Ivey, A. E., Daniels, T., Zalaquett, C. P., & Ivey, M. B. (2017). Neuroscience of attention: Empathy and counseling skills. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-based clinical approaches* (pp. 81–100). American Counseling Association. https://doi.org/10.1002/9781119375487.ch5

Ivey, A., & Ivey, M. (1998). Reframing DSM-IV: Positive strategies from developmental counseling and therapy. *Journal of Counseling and Development*, *76*, 334–350. https://doi.org/10.1002/j.1556-6676.1998.tb02550.x

Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2014). *Therapeutic lifestyle changes inventory*. Publisher.

Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2018). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (9th ed.). Cengage Learning.

Ivey, A. E., Ivey, M., & Zalaquett, C. P. (2018). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (9th ed.). Cengage.

Ivey, A. E., & Zalaquett, C. (2011). Neuroscience and counseling: Central Issue for social justice leaders. *Journal for Social Action in Counseling and Psychology, 3*(1)–11, 103–116. https://openjournals.bsu.edu/jsacp/article/view/341

Iwamasa, G. Y., & Hays, P. A. (2019). *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., 3–19). American Psychological Association.

Iwamasa, G. Y., Hsia, C., & Hinton, D. (2006). Cognitive–behavioral therapy with Asian Americans. In P. A. Hays & G. Y. Iwamasa (Eds.), *Culturally responsive cognitive–behavioral therapy: Assessment, practice, and supervision* (pp. 117–140). American Psychological Association.

Jacobs, M. (2003). *Sigmund Freud* (2nd ed.). SAGE Publications.

Jacobs, N., & Reupert, A. (2014). *The effectiveness of supportive counselling, based on Rogerian principles: A systematic review of recent international and Australian research*. Psychotherapy and Counselling Foundation of Australia.

Jacobson, E. (1938). *Progressive relaxation*. University of Chicago Press.

Jaffé, A. (1964). Symbolism in the visual arts. In C. G. Jung & M. L. von Franz (Eds.), *Man and his symbols* (pp. 230–271). Doubleday.

Jaffé, A. (1971). *From the life and work of C. G. Jung*. Harper & Row.

Jalali, F., Hashemi, S. F., & Hasani, A. (2019). Narrative therapy for depression and anxiety among children with imprisoned parents: A randomised pilot efficacy trial. *Journal of Child & Adolescent Mental Health*, *31*(3), 189–200. https://doi.org/10.2989/17280583.2019.1678474

Jalali, F., Hashemi, S., Kimiaei, S., Hasani, A., & Jalali, M. (2018). The effectiveness of solution-focused brief couple therapy on marital satisfaction among married prisoners and their wives. *International journal of offender therapy and comparative criminology*, *62*(10), 3023–3037. https://doi.org/10.1177/0306624X17733662

Jankowska, M (2019). Cultural modifications of cognitive behavioural treatment of social anxiety among culturally diverse clients: A systematic literature review. *The Cognitive Behaviour Therapist*, *12*(7), 1–25. https://doi.org/10.1017/S1754470X18000211

Jansson, B. S. (2020). *Social welfare policy and advocacy: Advancing social justice through 8 policy sectors* (2nd ed.). SAGE Publications.

Jeffcoat, T., & Hayes, S. C. (2012). A randomized trial of ACT bibliotherapy on the mental health of K–12 teachers and staff. *Behaviour Research and Therapy, 50*(9), 571–579. https://doi.org/10.1016/j.brat.2012.05.008

Johansson, R., Ekbladh, S., Hebert, A., Lindström, M., Möller, S., Petitt, E., Poysti, S., Larsson, M. H., Rousseau, A., Carlbring, P., Cuijpers, P., & Andersson, G. (2012). Psychodynamic guided self-help for adult depression through the internet: A randomised controlled trial. *PloS One, 7*(5), e38021. https://doi.org/10.1371/journal.pone.0038021

Johnson, S. A. (2019). REBT with religious people. In W. Dryden & M.E. Bernard (Eds.), *REBT with diverse client problems and populations* (pp. 323–339). Springer.

Johnson, W. B. (2001). To dispute or not to dispute: Ethical REBT with religious clients. *Cognitive and Behavioral Practice*, *8*, 39–47. https://psycnet.apa.org/doi/10.1016/S1077-7229(01)80042-0

Johnson, W. R., & Smith, E. W. L. (1997). Gestalt empty-chair dialogue versus systematic desensitization in the treatment of phobia. *Gestalt Review, 1*(2), 150–162. https://psycnet.apa.org/doi/10.2307/44394035

Johnson-Migalski, L., Victor, C., Velez-Giraldo, A., Chaney, M., & Moise, L. P. (2020). Adler's interview questions: Incorporating diversity and sociocultural contexts holistically. *The Journal of Individual Psychology*, *76*, 141–148.https://doi.org/10.1353/jip.2020.0024

Jones, E., Huey Jr., S. J., & Rubenson, M. (2018). Cultural competence in therapy with African Americans. In C. L. Frisby & W. T. O'Donohue (Eds.), *Cultural competence in applied psychology* (pp. 557–573). Springer.

Jones, J., & Wilson, W. (2006). *An incomplete education* (3rd ed.). Ballantine Books.

Jones, L. K. (2017a). Anatomy and brain development. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-based clinical approaches* (pp. 1–26). American Counseling Association. https://doi.org/10.1002/9781119375487.ch1

Jones, L. K. (2017b). Neurophysiological development across the life span. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-based clinical approaches* (pp. 27–44). American Counseling Association. https://doi.org/10.1002/9781119375487.ch2

Jones, L. K., Rybak, C., & Russell-Chapin, L. A. (2017). Neurophysiology of traumatic stress. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-based clinical approaches* (pp. 61–80). American Counseling Association. https://doi.org/10.1002/9781119375487.ch4

Jones-Smith, E. (2021). *Feminist and lesbian and gay therapy*. In E. Jones-Smith, *Theories of counseling and psychotherapy: An integrative approach* (3rd ed., pp. 364–389). SAGE Publications.

Jordan, J. V. (2000). The role of mutual empathy in relational/cultural therapy. *Journal of Clinical Psychology, 56*, 1005–1016. https://doi.org/10.1002/1097-4679(200008)56:8%3C1005::AID-JCLP2%3E3.0.CO;2-L

Jordan, J. V. (2001) A relational–cultural model: Healing through mutual empathy. *Bulletin of the Menninger Clinic, 65*, 92–103.

Jordan, J. V. (2017). Relational–cultural theory: The power of connection to transform our lives. *Journal of Humanistic Counseling, 56*, 228–243. https://doi.org/10.1002/johc.12055

Jordan, J. V. (2018). *Relational-cultural therapy* (2nd ed.). American Psychological Association.

Jordan, J. V., Kaplan, A. G., Miller, J. B., Stiver, I. P., & Surrey, J. L. (1991). *Women's growth in connection: Writings from the Stone Center*. Guilford Press.

Jung, C. G. (1916). *Psychology of the unconscious: A study of the transformations and symbolisms of the libido, a contribution to the history of the evolution of thought* (B. Moses, Trans.). Princeton University Press.
Jung, C. G. (1936). *The collected works of C. G. Jung: The archetypes and the collective unconscious* (Vol. 9). (R. F. C. Hull, Trans.). Pantheon.
Jung, C. G. (1954). *The collected works of C. G. Jung: The development of personality.* (R. F. C. Hull, Trans.). Pantheon.
Jung, C. G. (1957). Symbols of mother and of rebirth (R. F. C. Hull, Trans). In Sir H. Read, M. Fordham, and G. Adler (Eds.). *The collected works of C. G. Jung: The development of personality* (Vol. 5, pp. 219–238). Bollingen Foundation.
Jung, C. G. (1964a). *Psychological types* (H. G. Baynes, Trans.). Pantheon. (Original work published 1921)
Jung, C. G. (1964b). Approaching the unconscious. In C. G. Jung & M. L. von Franz (Eds.), *Man and his symbols* (pp. 18–103). Doubleday.
Jung, C. G. (1966a). *The collected works of C. G. Jung: The practice of psychotherapy* (Vol. 16, R. F. C. Hull, Trans.). Princeton University Press.
Jung, C. G. (1966b). *The collected works of C. G. Jung: The spirit in man, art, and literature* (Vol. 15, R. F. C. Hull, Trans.). Princeton University Press.
Jung, C. G. (1967). *The collected works of C. G. Jung: Alchemical studies* (Vol. 13, R. F. C. Hull, Trans.). Princeton University Press.
Jung, C. G. (1968a). *The collected works of C. G. Jung: The archetypes and the collective unconscious* (Vol. 9, part 1, R.F.C. Hull, Trans.). Princeton University Press.
Jung, C. G. (1968b). *The collected works of C. G. Jung: Psychology and alchemy* (Vol. 12, R. F. C. Hull, Trans.). Princeton University Press.
Jung, C. G. (1969a). *Studies in word-association: Experiments in the diagnosis of psychopathological conditions carried out at the psychiatric clinic of the University of Zurich under the direction of C. G. Jung*. Russell & Russell. (Original work published 1918)
Jung, C. G. (1969b). *The collected works of C. G. Jung: The structure and dynamics of the psyche* (Vol. 8, R. F. C. Hull, Trans.). Princeton University Press.
Jung, C. G. (1971). *The collected works of C. G. Jung: Psychological types* (Vol. 6, H. G. Baynes, Trans.). Princeton University Press.
Jung, C. G. (1976). *The collected works of C. G. Jung: The symbolic life: Miscellaneous writings* (Vol. 18, R. F. C. Hull, Trans.). Princeton University Press.
Jung, C. G. (2009). *The red book*. W. W. Norton & Co.
Jung, C. G., & Jaffé, A. (Eds.). (1961). *Memories, dreams, reflections*. (R. Winston & C. Winston, Trans.). Pantheon Books.
Jung, C. G., & von Franz, M. L. (Eds.). (1964). *Title*. Doubleday and Company.
Jung, C., G., & Campbell, J. (Eds.). (1971). *The portable Jung* (R. F. C. Hull, Trans.). Penguin Books. (Original work published 1928)
Jusoh, A. J. B. (2018). Choice theory and reality therapy in individual and group counseling in a Malaysian context. *International Journal of Choice Theory® and Reality Therapy*, *37*(2), 75–85.
Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical psychology: Science and practice*, *10*(2), 144–156. https://doi.org/10.1093/clipsy.bpg016
Kahneman, D. (2011). *Thinking, fast and slow*. Farrar, Straus, and Giroux.
Kaiser, C. (1995). *An interview with Kurt Adler on his 90th birthday.* Alfred Adler Institute of Northwestern Washington. http://www.adlerian.us/kurt-90.htm
Kamiya, J. (1969). Operant control of the EEG alpha rhythm and some of its reported effects on consciousness. In C. Tart (Ed.), *Altered states of consciousness* (pp. 489–501). Wiley.
Kandel, E. R. (1998). A new intellectual framework for psychiatry. *The American Journal of Psychiatry*, *155*(4), 457–469. https://doi.org/10.1176/ajp.155.4.457
Kaufman, M. T. (2007, July 25). Albert Ellis, 93, influential psychotherapist, dies. *New York Times*. http://www.nytimes.com/2007/07/25/nyregion/25ellis.html?ei=5088&en=fafd65d9cfba7311&ex=1343016000&partner=rssnyt&pagewanted=all
Kawamichi, H., Yoshihara, K., Sasaki, A. T., Sugawara, S. K., Tanabe, H. C., Shinohara, R., Sugiswa, y., Tokutake, K., Mochizuki, Y., Anme, T, & Sadato, N. (2015). Perceiving active listening activates the reward system and improves the impression of relevant experiences. *Social Neuroscience*, *10*, 16–26. https://doi.org/10.1080/17470919.2014.954732
Kayrouz, R., & Hansen, S. (2020). I don't believe in miracles: Using the ecological validity model to adapt the miracle question to match the client's cultural preferences and characteristics. *Professional Psychology: Research and Practice*, *51*, 223–236. https://doi.org.10.1037/pro0000283
Kayser, K., Watson, L. E., & Andrade, J. T. (2007). Cancer as a "we-disease": Examining the process of coping from a relational perspective. *Families, Systems, & Health*, *25*, 404–418. https://doi.org/10.1037/1091-7527.25.4.404
Kegan, R. (1982). *The evolving self.* Harvard University Press.
Kegan, R. (1994). *In over our heads*. Harvard University Press.
Keller, W., Westhoff, G., Dilg, R., Rohner, R., Studt, H. H., & The Study Group on Empirical Psychotherapy Research in Analytical Psychology. (2002). Efficacy and cost effectiveness aspects of outpatient (Jungian) psychoanalysis and psychotherapy—A catamnestic study. In M. Leuzinger-Bohleber & M.Target (Eds.), *Longer-term psychoanalytic treatment: Perspectives for therapists and researchers* (pp. 186–197). Whurr.
Kelly, M. S., & Maynard, B. R. (2014). Solution-focused approach with spiritual or religious clients. In J. S. Kim (Ed.), *Solution-focused brief therapy: A multicultural approach* (pp. 194–205). SAGE.

Kennedy, L., & Parker, S. H. (2018). Biofeedback as a stress management tool: A systematic review. *Cognition, Technology & Work, 211*, 161–190. https://doi.org/10.1007/s10111-018-0487-x

Kessel, F., Cole, P., & Johnson, D. (Eds.). (2014). *Self and consciousness: Multiple perspectives*. Psychology Press.

Kilman, C. (2013, Summer). *The gender spectrum*. Learning for Justice. https://www.learningforjustice.org/magazine/summer-2013/the-gender-spectrum

Kim, C. Y. (2016). Carl Gustav Jung and Granville Stanley Hall on religious experience. *Journal of Religion and Health, 55*, 1246–1260. https://doi/org/10.10007/s10943-016-2337-4

Kim, E., Seo, J., Paik, H., Sohn, S. (2020). The effectiveness of Adlerian therapy for hwa-byung in middle-aged South Korean women. *The Counseling Psychologist, 48*, 1082–1108. https://doi.org/10.1177/0011000020946799

Kim, J. (2018). Consideration of the applicability of person-centered therapy to culturally varying clients, focusing on the actualizing tendency and self-actualization—from East Asian perspective. *Person-Centered & Experiential Psychotherapies, 17*(3), 201–223. https://doi.org/10.1080/14779757.2018.1506817

Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice, 18*, 107–116. https://psycnet.apa.org/doi/10.1177/1049731507307807

Kim, J. S. (2014). *Solution-focused brief therapy: A multicultural approach*. SAGE Publications.

Kim, J. S., & Franklin, C. (2009). Solution-focused brief therapy in schools: A review of the literature. *Children and Youth Services Review, 31*, 464–470.

Kim, J., Jordan, S. S., Franklin, C., & Froerer, A. (2019). Is solution-focused brief therapy evidence-based? An update 10 years later. *Families in Society, 100*(2), 127–138. https://doi.org/10.1177/1044389419841688

Kirchner, M. (2000). Overview of Gestalt therapy theory. *Gestalt, 4*(3). http://www.g-gej.org/4-3/theoryoverview.html

Kirschenbaum, H. (1979). *On becoming Carl Rogers*. Delacorte Press.

Kirschenbaum, H. (2009). *The life and work of Carl Rogers*. American Counseling Association.

Kirschenbaum, H., & Henderson, V. (1989a). [Introduction to] A philosophy of persons. In H. Kirschenbaum & V. Henderson (Eds.), *The Carl Rogers reader* (pp. 398–401). Houghton Mifflin.

Kirschenbaum, H., & Henderson, V. (Eds.). (1989b). *Carl Rogers dialogues*. Houghton Mifflin.

Kirschenbaum, H., & Henderson, V. (1989c). Introduction. In H. Kirschenbaum & V. Henderson (Eds.), *The Carl Rogers reader* (pp. xi–xvi). Houghton Mifflin.

Kirschenbaum, H., & Henderson, V. (Eds.). (1989d). *The Carl Rogers reader*. Houghton Mifflin.

Kirschenbaum, H., & Henderson, V. (1989e). [Introduction to] A more human world. In H. Kirschenbaum & V. Henderson (Eds.), *The Carl Rogers reader* (pp. 434–435). Houghton Mifflin.

Kirschenbaum, H., & Jourdan, A. (2005). The current status of Carl Rogers and the person-centered approach. *Psychotherapy: Theory, Research, Practice, Training, 42*(1), 37–51.

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *The Counseling Psychologist, 12*(3), 43–45. https://doi.org/10.1177/0011000084123005

Kitchener, K. S. (1986). Teaching applied ethics in counselor education: An integration of psychological processes and philosophical analysis. *Journal of Counseling and Development, 64*(5), 306–311. https://doi.org/10.1002/j.1556-6676.1986.tb01117.x

Kluckhohn, F. R., & Strodtbeck, F. L. (1961). *Variations in value orientations*. Row, Petersen.

Knekt, P., Lindfors, O., Laaksonen, M. A., Renlund, C., Haaramo, P., Härkänen, T., Virtala, E., & Helsinki Psychotherapy Study Group. (2011). Quasi-experimental study on the effectiveness of psychoanalysis, long-term and short-term psychotherapy on psychiatric symptoms, work ability and functional capacity during a 5-year follow-up. *Journal of Affective Disorders, 132*(1–2), 37–47. https://doi.org/10.1016/j.jad.2011.01.014

Koemer, D. (2012). *Doing dialectical behavior therapy: A practical guide*. Guilford Press.

Kohlenberg, R. J., & Tsai, M. (1991). *Functional analytic psychotherapy: Creating intense and curative therapeutic relationships*. Plenum.

Kohtala, A., Muotka, J., & Lappalainen, R. (2017). What happens after five years? The long-term effects of a four-session acceptance and commitment therapy delivered by student therapists for depressive symptoms. *Journal of Contextual Behavioral Science, 6*(2), 230–238. https://doi.org/10.1016/j.jcbs.2017.03.003

Konkel L. (1998). A new intellectual framework for psychiatry. *The American Journal of Psychiatry, 155*(4), 457–459. https://doi.org/10.1176/ajp.155.4.457

Kottman, T., & Meany-Walen, K. (2016). *Partners in play: An Adlerian approach to play therapy* (3rd ed.). American Counseling Association.

Kozak, M. J., & Cuthbert, B. N. (2016). The NIMH research domain criteria initative: Background, issues, and pragmatics. *Psychophysiology, 53*, 286–297. https://doi.org/10.1111/psyp.12518

Krafft, J., Ferrell, J., Levin, M. E., & Twohig, M. P. (2018). Psychological inflexibility and stigma: A meta-analytic review. *Journal of Contextual Behavioral Science, 7*, 15–28. https://doi.org/10.1016/j.jcbs.2017.11.002

Kramer, R. (1995). The birth of client-centered therapy: Carl Rogers, Otto Rank, and "the beyond." *Journal of Humanistic Psychology, 35*(4), 54–110. https://psycnet.apa.org/doi/10.1177/00221678950354005

Krapp, K. (Ed.). (2005). Beck, Aaron Temkin. *Psychologists and their theories for students* (Vol. 1, pp. 67–91). Gale Cengage Publishers.

Kress, V. E., Seligman, L., & Reichenberg, L. W. (2021). *Theories of counseling and psychotherapy: Systems, strategies, and skills*. Pearson.

Krishnamurti, J. (1969). *Freedom from the known* (M. Lutyens, Ed.). Harper & Row.
Kuo, J. R., & Fitzpatrick, S. (2015). Dialectical behavior therapy. In E. Neukrug (Ed.), *The SAGE encyclopedia of theories in counseling and psychotherapy* (Vol. 1, pp. 292–297). Sage Publications.
Kupfersmid. J. (2012). The Oedipus complex: It made no sense then, it makes no sense now. In M. A. Holowchak (Ed.), *Radical claims in Freudian psychoanalysis: Point/counterpoint* (pp. 27–40). Jason Aronson.
Kylie, A. (2014). Behind the mirror: Reflective listening and its Tain in the work of Carl Rogers. *The Humanistic Psychologist, 42*(4), 354–369. http://dx.doi.org/10.1080/08873267.2014.913247
Lachman, G. (2010). *Jung the mystic: The esoteric dimensions of Carl Jung's life and teachings*. Penguin.
Lachman, G. (2015). Jung, Carl. In M. Cardin (Ed.), *Ghosts, spirits, and psychics: The paranormal from alchemy to Zombies* (pp. 133–136). ABC-CLIO.
Laezer, K. L. (2015). Effectiveness of psychoanalytic psychotherapy and behavioral therapy treatment in children with attention deficit hyperactivity disorder and oppositional defiant disorder. *Journal of Infant, Child, and Adolescent Psychotherapy, 14*(2), 111–128. https://doi.org/10.1080/15289168.2015.1014991
LaGuardia, A. (2023). Using counseling theories in multicultural contexts. In D. G. Hays & B. T. Erford (Eds.), *Developing multicultural counseling competency: A systems approach* (4th ed., pp. xx–xx). Pearson.
Laing, R. D. (1969). *Self and others*. Pelican Books.
Lambie, G. W., Hagedorn, W. B., & Ieva, K. P. (2010). Social–cognitive development, ethical and legal knowledge, and ethical decision making of counselor education students. *Counselor Education and Supervision, 49*, 228–246. https://psycnet.apa.org/doi/10.1002/j.1556-6978.2010.tb00100.x
Lambie, G. W., Smith, H. L., & Ieva. K. P. (2009). Graduate counseling students' levels of ego development, wellness, and psychological disturbance: An exploratory investigation. *Adultspan, 8*, 114–127. https://doi.org/10.1002/j.2161-0029.2009.tb00064.x
Landon, T. J., & Schultz, J. C. (2017). Exploring rehabilitation counseling supervisors' role in promoting counselor development of ethical fluency. *Rehabilitation Counseling Bulletin, 62*(1), 18–29. https://doi-org.proxy.lib.odu.edu/10.1177/0034355217728912
Landreth, G. L. (2012). *Play therapy: The art of the relationship (3rd ed.)*. Brunner-Routledge.
Längle, A., & Sykes, B. (2006). Viktor Frankl—Advocate for humanity: On his 100th birthday. *Journal of Humanistic Psychology, 46*(1), 36–47. https://doi.org/10.1177%2F0022167805281150
Langley, N., Ryerson, F., & Woolf, E. A. (1939). *The Wizard of Oz [original screenplay]*. http://www.aellea.com/script/wizardofoz.pdf
Lappalainen, P., Granlund, A., Siltanen, S., Ahonen, S., Vitikainen, M., Tolvanen, A., & Lappalainen, R. (2014). ACT internet-based vs face-to-face? A randomized controlled trial of two ways to deliver acceptance and commitment therapy for depressive symptoms: An 18-month follow-up. *Behaviour Research and Therapy, 61*, 43–54. https://doi.org/10.1016/j.brat.2014.07.006
Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy, 51*, 467–481. https://doi.org/10.1037/a0034332
Law, F. M., & Guo, G. J. (2017). Choice and hope: A preliminary study of the effectiveness of choice-based reality therapy in strengthening hope in recovery for women convicted of drug offences in Taiwan. *International Journal of Offender Therapy and Comparative Criminology, 61*(3), 310–333. https://doi.org/10.1177/0306624X15596392
Lawrence, G. (2000). Foreword. In E. Christopher & H. M. Solomon (Eds.), *Jungian thought in the modern world* (pp. xii–xviii). Free Association Books.
Lee, M. Y. (2013). Solution-focused brief therapy. *Encyclopedia of social work*. http://socialwork.oxfordre.com/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1039
Lee, S. Y., Xue, Q., Spira, A. O., & Lee, H. B. (2014). Racial and ethnic differences in depressive subtypes and access to mental health care in the United States. *Journal of Affective Disorders, 155*, 130–137. https://doi.org/10.1016/j.jad.2013.10.037
Leichsenring, F. (2005). Are psychodynamic and psychoanalytic therapies effective? A review of empirical data. *International Journal of Psychoanalysis, 36*(3), 841–868. https://doi.org/10.1516/RFEE-LKPN-B7TF-KPDU
Leichsenring, F., & Leibing, E. (2007). Psychodynamic psychotherapy: A systematic review of techniques, indications and empirical evidence. *Psychology and Psychotherapy: Theory, Research and Practice, 80*(2), 217–228. https://doi.org/10.1348/147608306X117394
Leichsenring, F., Masuhr, O., Jaeger, U., Rabung, S., Dally, A., Dümpelmann, M., Fricke-Neef, C., & Streeck, U. (2016). Psychoanalytic-interactional therapy versus psychodynamic therapy by experts for personality disorders: a randomized controlled efficacy-effectiveness study in cluster B personality disorders. *Psychotherapy and Psychosomatics, 85*(2), 71–80. https://doi.org/10.1159/000441731
Leman, K. (2015). *The birth order book: Why you are the way you are* (Rev. ed.). Revell.
Lennon, B. (2000). From "reality therapy" to "reality therapy in action." *International Journal of Reality Therapy, 20*(1), 41–46.
Lennon, J. (1980). *Beautiful boy* [Video]. YouTube. https://www.youtube.com/watch?v=Lt3IOdDE5iA
Lenz, A. S. (2016). Relational-cultural theory: Fostering the growth of a paradigm through empirical research. *Journal of Counseling and Development, 94*, 379–382. https://doi.org/10.1002/jcad.12095
Lenz, A. S., Speciale, M., & Aquilar, J. V. (2012). Relational–cultural therapy intervention with incarcerated adolescents: A single-case effectiveness design. *Counseling Outcome Research and Evaluation, 3*, 17–29.

Lenzenweger, M. F., Lane, M., Lorganger, A. W., & Kessler, R. C. (2007). DSM–IV personality disorders in the national comorbidity survey replication. *Biological Psychiatry, 62*, 553–564. https://doi.org/10.1016/j.biopsych.2006.09.019

Leszcz, M. (2015). Existential group psychotherapy. In E. S. Neukrug (Ed.). *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 365–368). SAGE Publications.

Letourneau, J. L. H. (2016). A decision-making model for addressing problematic behaviors in counseling students. *Counseling and Values*, *61*(2), 206–222. https://doi.org/10.1002/cvj.12038

Leuzinger-Bohleber, M., Hautzinger, M., Fiedler, G., Keller, W., Bahrke, U., Kallenbach, L., Kaufhold, J., Ernst, M., Negele, A., Schoett, M., Küchenhoff, H., Günther, F., Rüger, B., Beutel, M. (2018). Outcome of psychoanalytic and cognitive-behavioural long-term therapy with chronically depressed patients: A controlled trial with preferential and randomized allocation. *Canadian Journal of Psychiatry, 64*(1), 47–58. https://doi.org/10.1177%2F0706743718780340

Li, W., Zhang, L., Luo, X., Liu, B., Liu, Z., Lin, F., Liu, Z., Xie, Y., Hudson, M., Rathod, S., Kingdon, D., Husain, N., Liu, X., Ayub, M., & Naeem, F (2017). A qualitative study to explore views of patients', carers' and mental health professionals' to inform cultural adaptation of CBT for psychosis (CBTp) in China. *BMC Psychiatry, 17*(131), 1–9. https://doi.org/10.1186/s12888-017-1290-6

Liang, B., Tracy, A. J., Kenny, M. E., Brogan, D., & Gatha, R. (2010). The Relational Health Indices for Youth: An examination of reliability and validity aspects. *Measurement and Evaluation in Counseling and Development, 42,* 255–274. https://doi.org/

Liang, B., Tracy, A. J., Taylor, C. A., & Williams, L .M. (2002a). Mentoring college-age women: A relational approach. *American Journal of Community Psychology, 30,* 271–288. https://doi.org/10.1023/A:1014637112531

Liang, B., Tracy, A., Kenny, M., & Brogan, D. (2008). Gender differences in the relational health of youth participating in a social competency program. *Journal of Community Psychology, 36,* 499–514. https://doi.org/10.1002/jcop.20246

Liang, B., Tracy, A., Taylor, C. A., Williams, L. M., Jordan, J. V., & Miller, J. B. (2002b). The relational health indices: A study of women's relationships. *Psychology of Women Quarterly, 26,* 25–35. 10.1177/0748175609354596

Likhtik E, Popa D, Apergis-Schoute J, Fidacaro, G.A., & Paré, D. (2008). Amygdala intercalated neurons are required for expression of fear extinction. *Nature, 31,* 642–645. https://doi.org/10.1038/nature0716

Lillard, A. S., & Erisir, A. (2011). Old dogs learning new tricks: Neuroplasticity beyond the juvenile period. *Developmental Review*, *31*(4), 207–239. https://doi.org/10.1016/j.dr.2011.07.008

Lindquist, T. G. & Watkins, K. L. (2014). Modern approaches to modern challenges: A review of widely used parenting programs. *Journal of Individual Psychology, 70,* 148–165.https:// doi.org/ 10.1353/jip.2014.0013

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* Guilford Press.

Linehan, M. M. (1987a). Dialectical behavior therapy: A cognitive-behavioral approach to parasuicide. *Journal of Personality Disorders*, *1*(4), 328–333. https://doi.org/10.1521/pedi.1987.1.4.328

Linehan, M. M. (1987b). Dialectical behavior therapy for borderline personality disorder: Theory and method. *Bulletin of the Menninger Clinic*, *51*(3), 261–276.

Linehan, M. M. (1989). Dialectical behavior therapy: A treatment for borderline personality disorder. Translated into German as: Dialektische Verhaltenstherapie bei Borderline-Personlichkeitsstorungen. *Praxis der klinischen Verhaltensmedizin und Rehabilitation*, *8*, 220–227.

Linehan, M. M. (1993a). *Cognitive-behavioral therapy of borderline personality disorder.* Guilford Press.

Linehan, M. M. (1993b). *Skills training manual for treating borderline personality disorder.* Guilford Press.

Linehan, M. M. (2015a). *DBT skills training manual* (2nd ed.). Guilford Press.

Linehan, M. M. (2015b, Nov 17). *Marsha Linehan, PhD, ABPP—balancing acceptance and change: DBT and the future of skills training* [Video]. Family Action Network. https://www.familyactionnetwork.net/events/balancing-acceptance-and-change-dialectical-behavior-therapy-dbt-and-the-future-of-skills-training/

Linehan, M. M. (2016). Behavior therapy: Where we were, where we are and where we need to be going. *Cognitive and Behavioral Practice, 23*(4), 451–453. https://doi.org/10.1016/j.cbpra.2015.12.002

Linehan, M. M. (2017a, April 14). *Marasha Linehan discusses: How she learned radical acceptance* [Video]. https://www.youtube.com/watch?reload=9&v=OTG7YEWkJFI

Linehan, M. M. (2017b). *Curriculum vitae*. University of Washington. https://depts.washington.edu/uwbrtc/wp-content/uploads/Linehan-CV-Aug-2017.pdf

Linehan, M. M. (2020). *Building a life worth living: A memoir.* Random House.

Linehan, M. M. (2020). *Building a life worth living: A memoir.* Random House.

Linehan, M. M., & Wilks, C. R. (2015). The course and evolution of dialectical behavior therapy. *American Journal of Psychotherapy, 69*(2), 97–110. https://doi.org/10.1176/appi.psychotherapy.2015.69.2.97

Lines, L. M. (2018, May 9). *The myth of female hysteria and health disparities among women*. Research Triangle Institute. https://www.rti.org/insights/myth-female-hysteria-and-health-disparities-among-women

Lloyd-Hazlet, J., & Foster, V. A. (2017). Student counselors' moral, intellectual, and professional identity development. *Counseling and Values*, *62*(1), 90–105. https://doi.org/10.1002/cvj.12051

Lodge, J. M., & Harrison, W. J. (2019). The role of attention in learning in the digital age. *The Yale Journal of Biology and Medicine*, *92*, 21–28. https://doi.org/10.1038/nature07167

Looyeh, M. Y., Kamali, K., & Shafieian, R. (2012). An exploratory study of the effectiveness of group narrative therapy on the school behavior of girls with attention deficit/ hyperactivity symptoms. *Archives of Psychiatry & Nursing, 26*(5), 404–410. https://doi.org/10.1016/j.apnu.2012.01.001

Lorelle, S., & Michel, R. (2017). Neurocounseling: Promoting human growth and development throughout the life span. *Adultspan Journal*, *16*(2), 106–119. https://doi.org/10.1002/adsp.12039
Luders, E. (2014). Exploring age-related brain degeneration in meditation practitioners. *Annals of the New York Academy of Sciences*, *13071*(1), 82–88. https://doi.org/10.1111/nyas.12217
Lujan, S. K. (2015). Quality counseling: An examination of choice theory and reality therapy. *International Journal of Choice Theory and Reality Therapy, XXXIV*(2), 17–23.
Lukas, E., & Hirsch, B. Z. (2002). Logotherapy. In F. W. Kaslow, R. F. Massey, & S. D. Massey (Eds.), *Comprehensive handbook of psychotherapy: Interpersonal/humanistic/existential* (Vol. 3, pp. 333–356). Wiley.
Luke, C. (2016). *Neuroscience for counselors and therapists: Integrating the sciences of mind and brain*. SAGE Publications.
Luke, C., & Diambra, J. F. (2017). Neuro-informed group work. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-based clinical approaches* (pp. 179–194). American Counseling Association. https://doi.org/10.1002/9781119375487.ch11
Luke, C., & Field, T. A. (2017). Neuro-informed career-focused counseling. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-based clinical approaches* (pp. 195–210). American Counseling Association. https://doi.org/10.1002/9781119375487.ch12
Luke, C., Miller, R., & McAuliffe, G. (2019) Neuro-informed mental health counseling: A person-first perspective. *Journal of Mental Health Counseling*, *41*, 65–79. https://doi.org/10.17744/mehc.41.1.06
Lukow, H. R., & Godwin, E. (2015). Narrative family therapy. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 2, pp. 691–695). SAGE Publications.
Lundgren, T., Dahl, J., Melin, L., & Kies, B. (2006). Evaluation of acceptance and commitment therapy for drug refractory epilepsy: A randomized controlled trial in South Africa—A pilot study. *Epilepsia*, *47*(12), 2173–2179. https://doi.org/10.1111/j.1528-1167.2006.00892.x
Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., & Fletcher, L. (2012). Slow and steady wins the race: A randomized clinical trial of acceptance and commitment therapy targeting shame in substance use disorders. *Journal of Consulting and Clinical Psychology*, *80*(1), 43–53. http://dx.doi.org/10.1037/a0026070
Lutz, A. B. (2014). *Learning solution-focused therapy: An illustrated guide*. American Psychiatric Association.
Luyten, P., & Blatt, S. J. (2012). Psychodynamic treatment of depression. *Psychiatric Clinics*, *35*(1), 111–129.
Lv, B., Zhou, H., Liu, C., Guo, X., Jiang, K., Liu, Z., & Luo, L. (2018). The relationship between parental involvement and children's self-efficacy profiles: A person-centered approach. *Journal of Child and Family Studies*, *27*(11), 3730–3741. https://doi.org/10.1007/s10826-018-1201-6
Lynn, S. J., Polizzi, C. P., Aksen, D. E., & Sleight, F. (2022). Evidence-based psychotherapy: Rational emotive behavior therapy and beyond: Problems, pitfalls, and promises in evaluating outcomes. In W. Dryden (Ed.), *New directions in rational emotive behaviour therapy* (pp. 99–116). Routledge.
Machtiger, H. G. (1982). Countertransference/transference. In M. Stein (Ed.), *Jungian analysis* (pp. 86–110). Open Court.
Mack, K., & Kaufman, J. (2013). *Freud's mistress*. Berkley Publishing Group.
MacKay, J. (2010). Profile of Judith Worell. In A. Rutherford (Ed.), *Psychology feminist voices multimedia internet archive. Feminist Voices*. http://www.feministvoices.com/judith-worell/
Mackinson, R. A., & Young, J. S. (2012). Cognitive-behavioral therapy and the treatment of posttraumatic stress disorder: Where counseling and neuroscience meet. *Journal of Counseling & Development*, *90*, 131–140. http://dx.doi.org/10.1111/j.1556- · 6676.2012.00017.x.
MacKinnon, C. A. (2013). Intersectionality as a method: A note. *Journal of Women in Culture and Society*, *38*, 1019–1030. https://doi.org/10.1086/669570
MacLeod, R., & Elliott, R. (2014). Nondirective Person-centered therapy for social anxiety: A hermeneutic single-case efficacy design study of a good outcome case. *Person-Centered & Experiential Psychotherapies*, *13*(4), 294–311. https://doi.org/10.1080/14779757.2014.910133
Madigan, S. (2015). Michael White. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 2, pp. 1050–1053). SAGE Publications.
Madigan, S. (2019). *Narrative therapy* (2nd ed.). American Psychological Association.
Mahoney, M. J. (2003). *Constructivist psychotherapy: Theory and practice*. Guilford.
Makari, G. (2008). *Revolution in mind: The creation of psychoanalysis*. HarperCollins.
Manaster, G. J., Painter, G., Deutsch, D., & Overholt, B. J. (Eds.). (1977). *Alfred Adler: As we remember him*. North American Society of Adlerian Psychology.
Mann, A. (2019, March 20). *What is string theory? LiveScience*. https://www.livescience.com/65033-what-is-string-theory.html
Mann, D. (2020). *Gestalt therapy: 100 key points and techniques* (2nd ed.). Routledge.
Mason, C. P. (2016). Using reality therapy trained group counselors in comprehensive school counseling programs to decrease the academic achievement gap. *International Journal of Choice Theory and Reality Therapy*, *35*(2), 14–24.
Mason, C. P., Hughey, A. W., & Burke, M. G. (2019). Decreasing the academic achievement gap in P–12 schools by implementing Choice Theory and focusing on relationships. *International Journal of Choice Theory and Reality Therapy*, *39*(1), 20–26.
Masson, J. M. (1985). *The complete letters of Sigmund Freud to Wilhelm Fliess:* 1887–1904 (J. M. Masson, Trans.). Belknap Press of Harvard University Press.
Mattanza, G., Meier, I., & Schegel, M. (2006). *Seele und forschung (Soul and research)*. Karger.

Marsten, D., Epston, D., Markham, L. (2016). *Narrative therapy in Wonderland: Connecting with children's imaginative know-how*. W. W. Norton & Company.
May, R. (1967). *Psychology and the human dilemma*. W. W. Norton
Mayo Clinic. (1998–2022a). *EEG (electroencephalogram)*. https://www.mayoclinic.org/tests-procedures/eeg/about/pac-20393875
Mayo Clinic. (1998–2022b). *Healthy lifestyle consumer health: Mindfulness exercises*. https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/mindfulness-exercises/art-20046356
McAuliffe, G., & Eriksen, K. (Eds.). (2010). *Handbook of counselor preparation*. Association for Counselor Education and Supervision.
McClintock, A. S., Anderson, T., Patterson, C. L., & Wing, E. H. (2018). Early psychotherapeutic empathy, alliance, and client outcome: Preliminary evidence of indirect effects. *Journal of Clinical Psychology*, *74*(6), 839–848. https://doi.org/10.1002/jclp.22568
McCluskey, M. C. (2021). Revitalizing Alfred Adler: An echo for equality. *Clinical Social Work Journal*, 1–13. https://doi.org/10.1007/s10615-021-00793-0
McCurdy, A. (1982). Establishing and maintaining the analytical structure. In M. Stein (Ed.), *Jungian analysis* (pp. 47–67). Open Court.
McGowan, K. (2014, March 6). *The second coming of Sigmund Freud. Discover*. http://discovermagazine.com/2014/april/14-the-second-coming-of-sigmund-freud
McKenzie, S. (2006). Queering gender: Anima/animus and the paradigm of emergence. *Journal of Analytical Psychology, 51*, 401–421. https://doi.org/10.1111/j.0021-8774.2006.00599.x
McLynn, F. (1996). *Carl Gustav Jung*. St. Martin's Press.
McVeigh, A.K. (2016). *Spirituality in practice: An exploration into narrative practitioners' approaches to addressing spirituality in counselling practices [Master's thesis*, Unitec Institute of Technology]. *Handle.net*. https://hdl.handle.net/10652/3285
Meany-Walen, K. K., Bratton, S. C., & Kottman, T. (2014). Effects of Adlerian play therapy on reducing students' disruptive behaviors. *Journal of Counseling & Development*, *92*, 47–56. https://doi.org/10.1002/j.1556-6676.2014.00129.x
Meany-Walen, K. K., Bullis, Q., Kottman, T., & Dillman Taylor, D. (2015). Group Adlerian play therapy with children with off-task behaviors. *The Journal for Specialists in Group Work*, *40*(3), 294–314. https://doi.org/10.1080/01933922.2015.1056569
Meany-Whalen, K. K., Teeling, S., Davis, A., Artley, G., & Vignovich, A. (2016–2017). Effectiveness of a play therapy intervention on children's externalizing and off-task behaviors. *Professional School Counseling*, *20*, 89–101. https://doi.org/10.5330/1096-2409-20.1.89
Meara, N. M., Schmidt, L. D., & Day, J. D. (1996) Principles and virtues: A foundation for ethical decisions, policies, and character. *The Counseling Psychologist*, *24*(9), 4–77. https://doi.org/10.1177/0011000096241002
Mehl-Madrona, L. (2010). *Healing the mind through the power of story*. Bear & Company.
Meissner, W. W. (2001). Psychic reality in the psychoanalytic process. *Journal of the American Psychoanalytic Association*, *49*, 855–890.
Mencher, J. (1997). Intimacy in lesbian relationships: A critical examination of fusion. In J.V. Jordan, (Ed.), *Women's growth in diversity: More writings from the Stone Center* (pp. 311–330). Guilford Press.
Mercado, A., & Hinojosa, Y. (2017). Culturally adapted dialectical behavior therapy in an underserved community mental health setting: A Latina adult case study. *Practice Innovations*, *2*(2), 80–93. https://doi.org/10.1037/pri0000045
Mereish, E. H., & Poteat, V. P. (2015). A relational model of sexual minority mental and physical health: The negative effects of shame on relationships, loneliness, and health. *Journal of Counseling Psychology*, *62*(3), 425–437. https://doi.org/10.1037/cou0000088
Messer, S. B., & Abbass, A. A. (2010). Evidence-based psychodynamic therapy with personality disorders. In J. J. Magnavita (Ed.), *Evidence-based treatment of personality dysfunction: Principles, methods, and processes* (pp. 79–111). American Psychological Association.
Meuret, A. E., Twohig, M. P., Rosenfield, D., Hayes, S. C., & Craske, M. G. (2012). Brief acceptance and commitment therapy and exposure for panic disorder: A pilot study. *Cognitive and Behavioral Practice*, *19*(4), 606–618. https://doi.org/10.1016/j.cbpra.2012.05.004
Mickel, E. (2013). African-centered reality therapy parenting: An alternative paradigm. *Journal of Human Behavior in the Social Environment*, *23*(2), 278–286. https://doi.org/10.1080/10911359.2012.747347
Midgley, N., & Kennedy, E. (2011). Psychodynamic psychotherapy for children and adolescents: a critical review of the evidence base. *Journal of Child Psychotherapy*, *37*(3), 232–260. https://doi.org/10.1080/0075417X.2011.614738
Miller, N. S., & Katz, J. L. (1989). The neurological legacy of psychoanalysis. *Comprehensive Psychiatry*, *30*(2), 123–134. https://doi.org/10.1016/0010-440X(89)90064-3
Miller G, & de Shazer S. (2000). Emotions in solution-focused therapy: A re-examination. *Family Process*, *39*(1), 5–23. https://doi.org/10.1111/j.1545-5300.2000.39103.xdoi:
Miller, J. B. & Stiver, I. P. (1995). *Relational images and their meanings is psychotherapy* [Work in progress, No. 22]. Wellesley College, Stone Center for Developmental Services and Studies.
Miller, J. B. (Ed.) (1973). *Psychoanalysis and women*. Penguin Books.
Miller, J. B. (1976). *Toward a New Psychology of Women*. Beacon Press.
Miller, J. B. (n.d.). *Dr. Jean Baker Miller*. National Institutes of Health. https://cfmedicine.nlm.nih.gov/physicians/biography_225.html

Miller, J., & Stiver, I. P. (1997). *The healing connection: How women form relationships in therapy and in life*. Beacon Press.
Miller, R. (2016). Neuroeducation: Integrating brain-based psychoeducation into clinical practice. *Journal of Mental Health Counseling*, *38*, 103–115. https://doi.org/10. l7744/mehc.38.2.02
Millon, T. (1969). *Modern psychopathology: A biosocial approach to maladaptive learning and functioning*. W. B. Saunders.
Mirzaie, H., Mehraban, A. H., Hosseini, S. A., Fard, F. G., & Mehdi, J. O. (2019). Comparison of the effect of filial and Adlerian play therapy on attention and hyperactivity of children with attention deficit hyperactivity disorder: A randomized clinical trial. *Iranian Rehabilitation Journal*, *17*(4), 341–350. http://dx.doi.org/10.32598/irj.17.4.341
Misztal, M. L. (2010). Abject poverty to self-sufficiency: The integration of choice theory and reality therapy into a program developed to eradicate poverty. *International Journal of Choice Theory and Reality Therapy*, *29*(2), 59–69.
Momeni, M., & Honarparvaran, N. (2016). Comparative effectiveness Gestalt approach marital relations training based on religious teachings on treason attitude change couples covered by imam Khomeini Relief Committee. *Indian Journal of Positive Psychology*, *7*(4), 429–432.
Monakes, S., Garza, Y., Wiesner III, V., & Watts, R. A. (2011). Implementing Adlerian sand tray therapy with adult male substance abuse offenders: A phenomenological inquiry. *Journal of Addictions and Offender Counseling*, *31*, 94–107.
Montes, S. (2013, November). The birth of the neuro-counselor? *Counseling Today*, *56*(6), 32–40.
Moody, R. L. (2019). REBT and LGBTQ clients. In W. Dryden & M. E. Bernard (Eds.), *REBT with diverse client problems and populations* (pp. 359–381). Springer.
Moonshine, C., & Schaefer, S. (2019). *Dialectical behavior therapy: The clinician's guidebook for acquiring competency in DBT (Vol. I)*. Pesi Publishing and Medi.
Morgan, A. (2000). *What is narrative therapy? An easy-to-read introduction*. Dulwich Centre Publications.
Moridi, H., Kajbaf, M. B., & Mahmoodi, A. (2020). The effect of Islamic–Iranian reality therapy on couples' marital satisfaction, life satisfaction, and communication skills shiraz. *Knowledge & Research in Applied Psychology*, *21*(2), 13–21.
Morray, E. B., & Liang, B. (2005). Peace talk: A relational approach to group negotiation among Arab and Israeli youth. *International Journal of Group Psychotherapy*, *55*, 481–506. https://doi.org/10.1521/ijgp.2005.55.4.481
Morton, J., Snowdon, S., Gopold, M., & Guymer, E. (2012). Acceptance and commitment therapy group treatment for symptoms of borderline personality disorder: A public sector pilot study. *Cognitive and Behavioral Practice*, *19*(4), 527–544. https://doi.org/10.1016/j.cbpra.2012.03.005
Mosak, H. (2010). Early recollections as a projective technique. *Journal of Projective Techniques*, *22*(3), 302–311. https://doi.org/10.1080/08853126.1958.10380855
Moss, F. (1998). Biofeedback, mind–body medicine, and the higher limits of human nature. In D. Moss (Ed.). (1998). *Humanistic and transpersonal psychology: A historical and biographical sourcebook*. Greenwood Publishing.
Murphy, D., Elliott, R., & Carrick, L. (2019). Identifying and developing therapeutic principles for trauma-focused work in person-centered and emotion-focused therapies. *Counselling and Psychotherapy Research*, *19*(4), 497–507. https://doi.org/10.1002/capr.12235
Murphy, J. J. (2015). *Solution-focused counseling in schools* (3rd ed.). American Counseling Association.
Muto, T., Hayes, S. C., & Jeffcoat, T. (2011). The effectiveness of acceptance and commitment therapy bibliotherapy for enhancing the psychological health of Japanese college students living abroad. *Behavior Therapy*, *42*(2), 323–335. https://doi.org/10.1016/j.beth.2010.08.009
Myerhoff, B. (1982). Life history among the elderly: Performance, visibility, and re-membering. In J. Rub (Ed.), *A crack in the mirror: Reflexive perspectives in anthropology* (pp. 99–120). University of Pennsylvania Press.
Myerhoff, B. (1986). "Life not death in Venice": Its second life. In V. W. Turner & E. M. Bruner (Eds.), *The anthropology of experience* (pp. 261–286). University of Illinois Press.
Myerhoff, B. (2007). *Stories as equipment for living: Last talks and tales of Barbara Myerhoff* (rev. ed.). University of Michigan Press.
Myers & Briggs Foundation. (2022). *The 16 MBTI types*. http://www.myersbriggs.org/my-mbti-personality-type/mbti-basics/the-16-mbti-types.htm
Myers, J. E., & Sweeney, T. J. (2004). The indivisible self: An evidence-based model of wellness. *Journal of Individual Psychology*, *60*(3), 234–245. https://doi.org/10.1007/s10658-014-0538-y
Myers, J. E., & Young, J. (2012). Brain wave biofeedback: Benefits of integrating neurofeedback in counseling. *Journal of Counseling and Development*, *90*(1), 20–29. https://doi.org/10.1111/j.1556-6676.2012.00003.x
Naeem, F. (2019). Cultural adaptations of CBT: A summary and discussion of the special issue on Cultural Adaptation of CBT. *The Cognitive Behaviour Therapist*, *12*(40), 1–20. https://doi.org/10.1017/S1754470X19000278
Naeem, F., Habib, N., Gul, M., Khalid, M., Saeed, S., Farooq, S., Munshi, T., Gobbi, M., Husain, N., Ayib, M., & Kingdon, D. (2014). A qualitative study to explore patients', carers' and health professionals' views to culturally adapt CBT for psychosis (CBTp) in Pakistan. *Behavioural and Cognitive Psychotherapy*, *44*, 43–55. https://doi.org/10.1017/S1352465814000332
Naeem, F., Phiri, P., Munshi, T., Rathod, S., Ayub, M., Gobbi, M., & Kingdon, D. (2015). Using cognitive behaviour therapy with South Asian Muslims: Findings from the culturally sensitive CBT project. *International Review of Psychiatry*, *27*, 233–246. https://doi.org/10.3109/09540261.2015.1067598
Naeem, F., Phiri, P., Rathod, S., & Ayub, M. (2019). Cultural adaptation of cognitive-behavioural therapy. *British Journal of Psychological Advances*, *25*, 387–395. https://doi.oed/10.1192/bja.2019.15
Nathan, O., & Norden, H. (1960). *Einstein on peace*. Simon and Schuster.
National Association of Social Workers. (2021). *Code of ethics*. https://www.socialworkers.org/About/Ethics/Code-of-Ethics

National Institute of Mental Health. (n.d.). *Personality disorders*. https://www.nimh.nih.gov/health/statistics/personality-disorders.shtml
National Organization of Human Services. (2015). *Ethical standards for human services professionals*. https://www.nationalhumanservices.org/ethical-standards-for-hs-professionals
National Public Radio. (2005). *My lobtomomy: Howard Dully's journey*. https://www.npr.org/2005/11/16/5014080/my-lobotomy-howard-dullys-journey
National Research Council and Institute of Medicine. (2000). Committee on integrating the science of early childhood development. In J. P. Shonkoff & D. A. Phillips (Eds), *From neurons to neighborhoods: The science of early childhood development* (pp. 182–219). National Academies Press.
Navalta, C. P., McGee, L., & Underwood, J. (2018). Adverse childhood experiences, brain development, and mental health: A call for neurocounseling. *Journal of Mental Health Counseling*, *40*(3), 266–278. https://doi.org/10.17744/mehc.40.3.07
Nayeri, M. F., Soltanifar, A., Moharreri, F., & Akbarzadeh, F. (2021). A randomized controlled trial of group reality therapy in attention deficit hyperactivity disorder and oppositional defiant disorder in adolescents. *Iranian Journal of Psychiatry and Behavioral Sciences*, *15*(1).
Naz, S., Gregory, R., & Bahu, M. (2019). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. *The Cognitive Behaviour Therapist*, *12*(22), 1–17. https://doi.org/10.1017/S1754470X19000060.
Neale-McFall, C. W. (2015). Acceptance and commitment group therapy. In E. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 5–7). SAGE Publications.
Nelson-Becker, H. B. (2004). Spiritual, religious, nonspiritual, and nonreligious narratives in marginalized older adults: A typology of coping styles. *Journal of Religion, Spirituality & Aging*, *17*(1–2), 21–38. https://doi.org/10.1300/J496v17n01_02
Nelson-Becker, H., & Sangster, K. (2019) Recapturing the power of ritual to enhance community in aging. *Journal of Religion, Spirituality & Aging*, *31*(2) 153–167. https://doi.org/10.1080/15528030.2018.1532858
Neukrug, E. (2015). Prolonged exposure therapy. In E. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 2, pp. 806–808). SAGE Publications.
Neukrug, E. (Ed.). (2015). *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vols. 1–2). SAGE Publications.
Neukrug, E. (2017, February 2). Creative and novel approaches to empathy. Counseling Today. Retrieved from https://ct.counseling.org/2017/02/creative-novel-approaches-empathy/
Neukrug, E. (2020). *The essentials of testing and assessment: A practical guide for counselors, social workers, and psychologists* (3rd ed.). Cengage.
Neukrug, E., Bayne, H., Dean-Nganga, L., & Pusateri, C. (2013). Creative and novel approaches to empathy: A neo-Rogerian perspective. *Journal of Mental Health Counseling*, *35*(1), 29–42.
Neukrug, E., & Ellis, D. J. (2015). Albert Ellis. In E. S. Neukrug, T*he SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 333–335). SAGE Publications.
Neukrug, E., & Fawcett, R. C. (2020). *Essentials of testing and assessment: A practical guide for counselors, social workers, and psychologists* (3rd ed., enhanced). Cengage.
Neumann, E. (1994). *Fear of the feminine and other essays on feminine psychology*. Princeton University Press.
Neurofeedback Alliance. (n.d.). *Home page*. https://neurofeedbackalliance.org/
Newman, C. F. (2016). Cognitive restructuring/cognitive therapy. In C. M. Nezu & A. M. Nezu (Eds.,), *The Oxford handbook of cognitive and behavioral therapies* (pp. 118–141). Oxford University Press.
Nicholi, A. M. (2002). *The question of God: C. S. Lewis and Sigmund Freud debate God, love, sex, and the meaning of life*. Free Press.
Noormohamadi, P., Ahmadi, A., Jahani, Y., & Alidousti, K. (2021). The effect of Gestalt-based counseling on the level of self-esteem and intimate partner violence against pregnant women: A randomized control trial. *Iranian Journal of Nursing Midwifery Research*, *26*, 437–442.
Noormohamadi, S. M., Arefi, M., Afshaini, K., & Kakabaraee, K. (2019). The effect of rational–emotive behavior therapy on anxiety and resilience in students. *International Journal of Adolescent Medicine and Health*, 1–6. https://doi.org.10.1515/ijamh-2019-0099
Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy*, *55*(4), 303–315. http://dx.doi.org/10.1037/pst0000193
Norcross, J. C., & Wampold, B. E. (Eds.). (2019). *Psychotherapy relationships that work* (3rd ed., Vol. 2). Oxford University Press.
Norcross, J. C., Goldfried, M. R., & Arigo, D. (2016). Integrative theories. In J. C. Norcross, G. R. VandenBos, D. K. Freedheim, & B. O. Olatunji (Eds.), *APA handbook of clinical psychology: Theory and research* (pp. 303–332). American Psychological Association.
Northoff, G. (2012). Psychoanalysis and the brain—Why did Freud abandon neuroscience? *Frontiers in Psychology*, *3*. https://doi.org/10.3389/fpsyg.2012.00071
O'Connor, K. P. (2015). *A constructionist clinical psychology for cognitive behavior therapy*. Routledge.
O'Connell, B. (2003). Introduction to the solution-focused approach. In B. O'Connell & S. Palmer (Eds.), *Handbook of solution-focused therapy* (pp. 1–11). SAGE Publications.
O'Connell, B. (2012). *Solution-focused therapy* (3rd ed.). SAGE Publications.
O'Hanlon, B., & Weiner-Davis, M. (2003). *In search of solutions: A new direction in psychotherapy* (Rev. ed.). W.W. Norton & Company.

O'Kelly, M. (2011). Psychometric properties of the O'Kelly Women's Belief Scales. *Journal of Rational–Emotive Cognitive-Behavior Therapy, 29*(3), 145–157. https://doi.org/10.1007/s10942-010-0120-2
O'Kelly, M., & Gilson, K. (2019). REBT with women. In W. Dryden & M.E. Bernard (Eds.), *REBT with diverse client problems and populations* (pp. 303–321). Springer.
Ong, J. C., Ulmer, C. S., & Manber, R. (2012). Improving sleep with mindfulness and acceptance: A metacognitive model of insomnia. *Behaviour Research and Therapy, 50*(11), 651–660. https://doi.org/10.1016/j.brat.2012.08.001
Orsolini, L., Pompili, S., Salvi, V., & Volpe, U. (2021). A systematic review on telemental health in youth mental health: Focus on anxiety, depression and obsessive-compulsive disorder. *Medicina*, *57*(8), 793–822. https://doi.org/10.3390/medicina57080793
Öst, L.-G. (2014). The efficacy of acceptance and commitment therapy: An updated systematic review and meta-analysis. *Behaviour Research and Therapy, 61*, 105–121. https://doi.org/10.1016/j.brat.2014.07.018
Öst, L.-G. (2017). Rebuttal of Atkins et al. (2017) critique of the Öst (2014) meta-analysis of ACT. *Behaviour Research and Therapy, 97*, 273–281. https://doi.org/10.1016/j.brat.2017.08.008
Özer, Ö., Yöntem, M.K. & Kan, Y. (2021). The effect of Tree of Life career counselling program on secondary schoolers' career decision-making self-efficacy. *International Journal of Education Technology and Scientific Researches*, *6*(14), 319–348. http://dx.doi.org/10.35826/ijetsar.269
Öztürk, A. G. (2019). Gestalt group practice for increasing awareness of university students. *International Journal of Psychology and Educational Studies*, *6*(3), 1–8. https://doi.org/10.17220/ijpes.2019.03.001
Padesky, C. A., & Beck, A. T. (2003). Science and philosophy: Comparison of cognitive therapy and rational emotive behavior therapy. *Journal of Cognitive Psychotherapy: An International Quarterly, 17*(3), 211–225.
Paivio, S. C., & Greenberg, S. (1995). Resolving "unfinished business": Efficacy of experiential therapy using empty-chair dialogue. *Journal of Consulting and Clinical Psychology, 63*(3), 419–425. https://psycnet.apa.org/doi/10.1037/0022-006X.63.3.419
Panksepp, J., & Solms, M. (2012). What is neuropsychoanalysis? Clinically relevant studies of the minded brain. *Trends in Cognitive Science*, *16*, 6–8. https://doi.org/10.1016/j.tics.2011.11.005
Paris, R., & Dubas, N. (2005). Staying connected while nurturing an infant: A challenge of new motherhood. *Family Relations*, *54*, 72–83. https://doi.org/10.1111/j.0197-6664.2005.00007.x
Parish, J., & Parish, T. (2019). The role of choice, viewed anciently and today. *International Journal of Choice Theory and Reality Therapy*, *38*(2), 33–35.
Park, J. W., & Kim, H. S. (2021). The effects of group counseling utilizing narrative therapy on self-esteem, stress response, and insight for individuals with alcohol dependency. *Journal of Creativity in Mental Health*, 1–30. https://doi.org/10.1080/15401383.2021.1972885
Park, S., & White, P. (2017). *Michael White memorial: Sue Park and Paul White*. Narrative Practices. http://narrativepractices.com.au/michael-white/michael-white-memorial-sue-park-and-paul-white (site inactive on 2/12/2022)
Pascal, E. (1992). *Jung to live by*. Warner Books.
Patrick, S., & Connolly, C. M. (2013). The privilege project: A narrative approach for teaching social justice and multicultural awareness. *The Journal of Systemic Therapies*, *32*(1), 70–86. https://doi.org/10.1521/jsyt.2013.32.1.70
Pattakos, A. (2008). *The prisoners of our thoughts: Viktor Frankl's principles for discovering meaning in life and work*. Berret-Kohler Publishers.
Payne, M. (2006). *Narrative therapy*. SAGE Publications.
Pearse, J. (2008, April 28). Michael White dies: Used stories as therapy. *The New York Times*. http://www.nytimes.com/2008/04/28/us/28white.html
Pedersen, P. B., Crethar, H., & Carlson, J.U. (2008). *Inclusive cultural empathy: Making relationships central in counseling and psychotherapy*. American Psychological Association.
Pederson, L. (2015). *Dialectical behavior therapy: A contemporary guide for practitioners*. John Wiley & Sons.
Peniston, E. G., & Kulkosky, P. J. (1989). Alpha-theta brainwave training and beta-endorphin levels in alcoholics. *Alcoholism: Clinical and Experimental Research*, *13*(2), 271–279. https://doi.org/10.1111/j.1530-0277.1989.tb00325.x
Perls, F. (1942/1947). *Ego, hunger, and aggression: A revision of Freud's theory and method*. G. Allen and Unwin Ltd.
Perls, F. (1969a). *Gestalt therapy verbatim*. Real People Press.
Perls, F. (1969b). *In and out of the garbage pail*. Real People Press.
Perls, F. (1970). Four lectures. In J. Fagan & I. L. Shepherd (Eds.), *Gestalt therapy now* (pp. 14–46). Harper & Row.
Perls, F. (1973). *The Gestalt approach and eyewitness to therapy*. Science and Behavior Books.
Perls, F. (1978). Cooper Union forum-lecture series: "The self," and finding self through Gestalt therapy. *Gestalt Journal*, *1*(1), 54–73.
Perls, F., Hefferline, R., & Goodman, P. (1951). *Gestalt therapy: Excitement and growth in human personality*. Julian Press.
Perry, W. G. (1970). *Forms of intellectual and ethical development in the college years: A scheme*. Holt, Rinehart, & Winston.
Perryman, K. L., & Bowers, L. (2018). Turning the focus to behavioral, emotional, and social well-being: The impact of child-centered play therapy. *International Journal of Play Therapy*, *27*(4), 227–241. https://doi.org/10.1037/pla0000078
Pham, A. V., Goforth, A. N., Chun, H., Castro-Olivo, S., & Costa, A. (2017). Acculturation and help-seeking behavior in consultation: A sociocultural framework for mental health service. *Journal of Educational and Psychological Consultation*, *27*(3), 271–288. https://doi.org/10.1080/10474412.2017.1287574

Pichot, T. (2105). Steve de Shazer and Insoo Kim Berg. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 275–278). SAGE Publications.
Pickersgill, M. D. (2013). Debating DSM-5: Diagnosis and the sociology of critique. *Journal of Medical Ethics, 0*, 1–5. https://doi.org/10.1136/medethics-2013-101762
Pinto, R. A., Kienhuis, M., Slevison, M., Chester, A., Sloss, A., & Yap, K. (2017). The effectiveness of an outpatient acceptance and commitment therapy group programme for a transdiagnostic population. *Clinical Psychologist, 21*(1), 33–43. https://doi.org/10.1111/cp.12057
Podina, I. R., & David, D. (2017). Acceptance and commitment therapy. In A. Vernon & K. A. Doyle (Eds.), *Cognitive behavior therapies: A guidebook for practitioners* (pp. 177–208). American Counseling Association.
Polster, E., & Polster, M. (1973). *Gestalt therapy integrated: Contours of theory and practice*. Brunner/Mazel.
Polster, E., & Polster, M. (1999). *From the radical center: The heart of Gestalt therapy*. The Gestalt Institute of Cleveland Press.
Popkin, M. H. (2014). Active Parenting: 30 years of video-based parent education. *Journal of Individual Psychology, 70*, 166–176. https://doi.org/10.1353/jip.2014.0014
Post, P. B., Phipps, C. B., Camp, A. C., & Grybush, A. L. (2019). Effectiveness of child-centered play therapy among marginalized children. *International Journal of Play Therapy, 28*(2), 88–97. https://doi.org/10.1037/pla0000096
Pouravari, M., Zandipour, T., Pouravari, M., & Salehi, S. (2018). The effectiveness of group choice theory and reality therapy training on reducing the aggression in female students. *International Journal of Applied Behavioral Sciences, 3*(4), 50–56. https://doi.org/ 10.22037/ijabs.v3i4.17072
Powers, M. B., Zum Vörde Sive Vörding, M. B., & Emmelkamp, P. M. G. (2009). Acceptance and commitment therapy: A meta-analytic review. *Psychotherapy and Psychosomatics, 78*(2), 73–80. https://doi.org/10.1159/000190790
Powers, W. T. (1973). *Behavior: The control of perception*. Aldine Publishing Company.
Pretorius, G., & Pfeifer, N. (2010). Group art therapy with sexually abused girls. *South African Journal of Psychology, 40*(1), 63–73. https://psycnet.apa.org/doi/10.1177/008124631004000107
Prinz, J., Arkin, S., & Gelkopf, M. (2008). Hadarim: A description and evaluation of a school-based Adlerian parenting program in Israel. *Journal of Individual Psychology, 64*, 38–54.
Purgason, L. L., Avent, J. R., Cashwell, C. S., Jordan, M. E., & Reese, R. F. (2016). Culturally relevant advising: applying relational-cultural theory in counselor education. *Journal of Counseling & Development, 94*(4), 429–436. https://doi.org/10.1002/jcad.12101
Quinn. A. (2012). A person-centered approach to multicultural counseling competence. *Journal of Humanistic Psychology, 53*(2), 202–251. http://dx.doi.org/10.1177/0022167812458452
Raffagnino, R. (2019). Gestalt therapy effectiveness: A systematic review of empirical evidence. *Open Journal of Social Sciences, 7(6)*, 66–83. https://doi.org/10.4236/jss.2019.76005
Ramaiya, M., Fiorillo, D., Regmi, U., Robins, C., & Kohrt, B. (2017). A cultural adaptation of dialectical behavior therapy in Nepal. *Cognitive and Behavioral Practice, 24*(4), 428–444. https://doi.org/10.1016/j.cbpra.2016.12.005
Rank, O. (1996). *A psychology of difference: The American lectures*. Princeton University Press.
Raskin, J. D., & Debany, A. E. (2017). The inescapability of ethics and the impossibility of "anything goes": A constructivist model of ethical meaning making. *Journal of Constructivist Psychology, 31*(4), 343–360. https://doi.org/10.1080/10720537.2017.1383954
Ratanashevorn, R., & Brown, E. C. (2021). "Alone in the rain(bow)": Existential therapy for loneliness in LGBTQ+ clients. *Journal of LGBTQ Issues in Counseling, 15*, 110–127. https://doi.org/10.1080/15538605.2021.1868375
Ratey, J. (2008). *Neuroscience and the brain: Implications for counseling and therapy* [DVD]. Old Dominion University Libraries. https://www-academicvideostore-com.proxy.lib.odu.edu/microtraining
Rathod, S, Phiri, P, & Naeem, F (2019). An evidence-based framework to culturally adapt cognitive behaviour therapy. *The Cognitive Behaviour Therapist, 12*(10), 1–15. https://doi.org/10.1017/S1754470X18000247
Rathod, S., Kingdom, D., Pinniti, N., Turkington, D., & Phirir, P. (2015). *Cultural adaptation of CBT for serious mental illness: A guide for training and practice*. Wiley.
Rathod, S., Pinninti, N., Irfan, M., Gorczynski, P., Rathod, P., Gega, L., & Naeem, F. (2017). Mental health service provision in low- and middle-income countries. *Health Services Insights, 10*, 1–7. https://doi.org/10.1177/1178632917694350
Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice: Integration, theory, and application* (4th ed.). American Counseling Association.
Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2015). *Multicultural and social justice counseling competencies: Guidelines for the counseling profession*. American Counseling Association. https://www.counseling.org/docs/default-source/competencies/multicultural-and-social-justice-counseling-competencies.pdf?sfvrsn=8573422c_22
Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development, 44*, 28–48. https://doi.org/10.1002/jmcd.12035
Raque-Bogdan, T. L. (2019). Relational cultural theory and cancer: Addressing the social well-being of a growing population. *Practice Innovations, 4*(2), 99–111. https://doi.org/10.1037/pri0000087
Read, Sir H., Fordham, M., Adler, G., & McGuire, W. (Eds.). (1957). *The collected works of C. G. Jung* (R. F. C. Hull, Trans.). The Bollingen Foundation.
Re-Authoring Teaching. (2010–2022). *About: What is narrative therapy*? https://reauthoringteaching.com/about/what-is-narrative-therapy/michael-white-overview/

Reiter, K., Andersen, S. B., & Carlsson, J. (2016). Neurofeedback treatment and posttraumatic stress disorder. *The Journal of Nervous and Mental Disease*, *204*(2), 69–77. https://doi.org/10.1097/NMD.0000000000000418
Remley, T. P., & Herlihy, B. (2019). *Ethical, legal, and professional issues in counseling* (6th ed.). Pearson.
Resnick, R. W. (2015a). Fritz Perls. In E.S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 2, pp. 761–764). SAGE Publications.
Resnick, R. W. (2015b). Gestalt therapy. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 456–462). SAGE Publications.
Reynolds, M. (2010, November 7). The fine art of female assertiveness: How to get your way by being diplomatically assertive. *Psychology Today.* https://www.psychologytoday.com/blog/wander-woman/201011/the-fine-art-female-assertiveness
Ribeiro, E., Fernandes, C., Santos, B., Ribeiro, A., Coutinho, J., Angus, L., & Greenberg, L. (2014). The development of therapeutic collaboration in a good outcome case of person-centered therapy. *Person-Centered & Experiential Psychotherapies*, *13*(2), 150–168. https://doi.org/10.1080/14779757.2014.893250
Ribi, A. (2013). *The search for roots: C. G. Jung and the tradition of gnosis.* Peter Lang Publishing.
Ricard, R. J. (2015). Adlerian group therapy. In E. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 27–30). SAGE Publications.
Richert, A. J. (2010). *Integrating existential and narrative therapy: A theoretical base for eclectic practice.* Duquesne University Press.
Rice, R. (2015). Cognitive-behavioral therapy. In E. S. Neukrug (Ed.), *The SAGE Encyclopedia of Theory in Counseling and Psychotherapy* (Vol. 1, pp. 194–199). SAGE Publications.
Rice, R. (2015). Michael White. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 2, pp. 695–701). SAGE Publications.
Riddell, P. (2016). Metaphor, simile, analogy and the brain. *Changing English: Studies in Culture and Education, 23*(4), 363–374. https://doi.org/10.1080/1358684X.2016.1228443
Ridley, C. R., Kelly, S. M., Mollen, D. (2011). Microskills training: Evolution, reexamination, and call for reform. *The Counseling Psychologist*, *39*(6), 800–824. https://journals.SAGEpub.com/doi/pdf/0.1177/0011000010378438
Rizvi, S. L., Steffel, L. M., & Carson-Wong, A. (2013). An overview of dialectical behavior therapy for professional psychologists. *Professional Psychology: Research and Practice*, *44*(2), 73–80. https://doi.org/10.1037/a0029808
Robbins, J. H. (1985). The appointment hassle: Clues about women's themes of separation-individuation. In L. B. Rosewater, &, L. E. A. Walker (Eds.), *Handbook of Feminist Therapy: Women's issues in psychotherapy* (pp. 1–4). Springer.
Robins, C. J. (2002). Zen principles and mindfulness practice in dialectical behavior therapy. *Cognitive and Behavioral practice*, *9*(1), 50–57. https://doi.org/10.1016/S1077-7229(02)80040-2
Robinson, T., Jacobsen, R. M., & Foster, T. (2015). Group narrative therapy for women with attention-deficit/hyperactivity disorder. *Adultspan, 14*, 24–34. https://doi.og/10/1002/j.2161-0029-2015.00034.x
Rock, D., Siegal, D. J., Poelmans, S. A. Y., & Payne, J. (2012). The healthy mind platter. *NeuroLeadership Journal*, (4), 1–23.
Roesler, C. (2013). Evidence for the effectiveness of Jungian psychotherapy: A review of empirical studies. *Behavioral Sciences, 3*, 562–575. https:/doi/org/10.3390/bs3040562.
Roesler, C. (Ed.). (2018). *Research in analytical psychology: Empirical research*. Routledge.
Roesler, C. (2020). Contemporary psychotherapy research, psychodynamic psychotherapy, and Jungian analysis. *Psychologia*, *62*(2), 94–105. https://doi.org/10.2117/psysoc.2020-B008
Rogers, C. R. (1931). *Measuring personality adjustment in children nine to thirteen years of age*. Teachers College.
Rogers, C. R. (1939). *The clinical treatment of the problem child*. Houghton Mifflin.
Rogers, C. R. (1942). *Counseling and psychotherapy.* Houghton Mifflin.
Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications and theory.* Houghton Mifflin.
Rogers, C. R. (1957a). A note on the "nature of man." *Journal of Counseling Psychology, 4*(3), 199–203. https://psycnet.apa.org/doi/10.1037/h0038382
Rogers, C. R. (1957b). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103.
Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of science, Vol. 3, Formulations of the person and the social context* (pp. 184–256). McGraw-Hill.
Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy.* Houghton Mifflin.
Rogers, C. R. (1967). Some learnings from a study of psychotherapy with schizophrenics. In C. R. Rogers & B. Stevens (Eds.), *Person to person: The problem of being human* (pp. 181–192). Real People Press.
Rogers, C. R. (1969). *Freedom to learn: A view of what education might become*. Charles Merrill.
Rogers, C. R. (1970). *Carl Rogers on encounter groups*. Harper and Row.
Rogers, C. R. (1972). *Becoming partners: Marriage and its alternatives*. Delacorte Press.
Rogers, C. R. (1977). *Carl Rogers on personal power: Inner strength and its revolutionary impact*. Delacorte Press.
Rogers, C. R. (1980). *A way of being*. Houghton Mifflin.
Rogers, C. R. (1986). Reflection of feelings. *Person-Centered Review, 1(4)*, 375–377.
Rogers, C. R., Gendlin, E.T., Kiesler, D. J., & Truax, C. B. (1967). *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics*. University of Wisconsin Press.

Rojas, D. C., & Wilson, L. B. (2014). γ-band abnormalities as markers of autism spectrum disorders. *Biomarkers in medicine*, *8*(3), 353–368. https://doi.org/10.2217/bmm.14.15

Ronan, K. R., Davies, G., Wikman, R., Canoy, D., Jarrett, M., & Evans, C. (2016). Family-centered, feedback-informed therapy for conduct disorder: Findings from an empirical case study. *Couple and Family Psychology: Research and Practice*, *5*(3), 137–156. https://doi.org/10.1037/cfp0000059

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. "At last the Dodo said, 'Everybody has won and all must have prizes.'" *American Journal of Orthopsychiatry, 6*, 412–415.

Rosidi, R., Sutoyo, A., & Purwanto, E. (2018). Effectiveness of reality therapy group counseling to increase the self-esteem of students. *Jurnal Bimbingan Konseling*, *7*(1), 12–16.

Ross-Shefiff, F., Edwards, J. B., & Orme, J. (2017). Relational mentoring of doctoral social work students at historically black colleges and universities. *Journal of Teaching in Social Work*, *37*(1), 55–70. https://doi.org/10.1080/08841233.2016.1270250

Rost, A. D., Wilson, K., Buchanan, E., Hildebrandt, M. J., & Mutch, D. (2012). Improving psychological adjustment among late-stage ovarian cancer patients: Examining the role of avoidance in treatment. *Cognitive and Behavioral Practice*, *19*(4), 508–517. https://doi.org/10.1016/j.cbpra.2012.01.003

Rowland, S. (2019). *C. G. Jung in the humanities: Taking the soul's path*. Routledge.

Roy, J. (2014). *William Glasser: Champion of choice*. Zeit, Tucker & Theisen.

Royle, J., & Brown, C. G. (2014). *School administrators' perceptions of the achievement gap between African American students and White students* (EJ1105718). https://eric.ed.gov/?id=EJ1105718

Rubin, S., & Lichtanski, K. L. (2015). Existential therapy. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 368–373). SAGE Publications.

Rubin, S. I., & Powers, N. (2005). *Analyzing the San Francisco psychotherapy research project*. www.sirseth.net/doc/SFresearch.pdf

Ruiz, F. J. (2012). Acceptance and commitment therapy versus traditional cognitive-behavioral therapy: A systematic review and meta-analysis of current empirical evidence. *International Journal of Psychology and Psychological Therapy, 12*(3), 333–358.

Russell-Chapin, L. A. (2016). Integrating neurocounseling into the counseling profession: An introduction. *Journal of Mental Health Counseling*, *38*(2), 93–102. https://doi.org/10.17744/mehc.38.2.01

Russell-Chapin, L. A. (2017a). Neurocounseling assessment. In T. A. Field, L. K. Jones, & L. A. Russell-Chapin (Eds.), *Neurocounseling: Brain-based clinical approaches* (pp. 115–132). American Counseling Association. https://doi.org/10.1002/9781119375487.ch7

Russell-Chapin, L. A. (2017b). The power of neurocounseling and self-regulation skills. In J. K. Edwards, A. Young, & H. J. Nikels (Eds.), *Handbook of strengths-based clinical practices: Finding common factors* (pp. 151–163). Routledge.

Rybak, C., Russell-Chapin, L., & Moser, M. (2000). Jung and theories of gender development. *Journal of Humanistic Counseling, Education and Development, 38*(3), 152–161.

Sa'ad, F. M., Yusoof, F., Nen, S., & Subhi, N. (2014). The effectiveness of person-centered therapy and cognitive psychology add-in group counseling on self-concept, depression and resilience of pregnant out-of-wedlock teenagers. *Procedia—Social and Behavioral Sciences, 114*, 927–932. https://doi.org/10.1016/j.sbspro.2013.12.809

Saadati, H., & Lashani, L. (2013). Effectiveness of gestalt therapy on self-efficacy of divorced women. *Procedia-Social and Behavioral Sciences, 84*, 1171–1174. https://doi.org/10.1016/j.sbspro.2013.06.721

Sackett, C. R., & Jenkins, A. R. (2019). Utilizing relational cultural theory in addressing sexism in the counseling relationship. *Journal of Creativity in Mental Health, 14*, 492–498. https://doi.org/10.1080/15401383.2019.1632768

Salvatore, R. A. (2001). *Sea of swords*. Wizards of the Coast, Inc.

Schaefle, S., Smaby, M. H., Maddux, C. D., & Cates, J. (2005). Counseling skills attainment, retention, and transfer as measured by the Skilled Counseling Scale. *Counselor Education and Supervision*, *4*, 280–292. https://doi.org/10.1002/j.1556-6978.2005.tb01756.x

Schoenberg, P. (2000). *The impact of Gestalt group therapy on persons with borderline personality disorder (group therapy)*. Dissertation Abstracts International Section A: Humanities and Social Sciences, 60(7-A). (Order no.: EH9939729)

Schwartz, J., & Begley, S. (2003). *The mind and the brain: Neuroplasticity and the power of mental force*. Harper Collins.

Scott, J. (2005). *Electra after Freud: Myth and culture*. Cornell University Press.

Scott, J., & Freeman, A. (2010). Beck's cognitive therapy. In N. Kazantzis, M. A. Reinecke, & A. Freeman (Eds.) *Cognitive and behavioral theories in clinical practice* (pp. 28–75). Guilford Press.

Scott, W. C., Kaiser, D., Othmer, S., & Sideroff, S. I. (2005). Effects of an EEG biofeedback protocol on a mixed substance abusing population. *The American Journal of Drug and Alcohol Abuse*, *31*(3), 455–469. https://doi.org/10.1081/ADA-200056807

Schmit, E. L., Schmit, M. K., & Lenz, A. S. (2016). Meta-analysis of solution-focused brief therapy for treating symptoms of internalizing disorders. *Counseling Outcome Research and Evaluation*, *7*(1), 21–39. https://doi.org/10.1177/2150137815623836

Sedgwick, D. (2017). *The wounded healer: Countertransference from a Jungian perspective*. Routledge.

Segal, R. A. (1998). *Jung on mythology: From symbols of mother and rebirth*. Princeton University Press.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2013). *Mindfulness-based cognitive therapy for depression* (2nd ed.). Guilford Press.

Selekman, M. D. (1997). *Solution-focused therapy with children*. Guilford Press.

Selesnick, S. T. (1966). Alfred Adler: The psychology of the inferiority complex. In F. Alexander, S. Eisenstein, & M. Grotjahn (Eds.), *Psychoanalytic pioneers* (pp. 78–86). Basic Books.
Seligman, M. E. P. (1995) The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist*, *50*, 965–974. https://doi.org/10.1037/0003-066X.50.12.965
Shapiro, F. (2002). EMDR treatment: Overview and integration. In F. Shapiro (Ed.), *EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism* (pp. 27–56). American Psychological Association.
Shapiro, F., & Forrest, M. S. (1997). *EMDR: The breakthrough "eye movement" therapy for overcoming anxiety, stress, and trauma*. Perseus Books.
Shapiro, F., & Solomon, R. (2015). Eye movement desensitization and reprocessing therapy. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 389–394). SAGE Publications.
Shapiro, J. P. (2015). *Child and adolescent therapy: Science and art* (2nd ed.). John Wiley & Sons.
Shapiro, R. (2005). (Ed.). *EMDR solutions: Pathways to healing*. W. W. Norton.
Shapiro, R. (2009). (Ed.). *EMDR solutions II: For depression, eating disorders, performance, and more*. W. W. Norton.
Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, *65*(2), 98–109. https:// doi.org/10.1037/a0018378
Shepard, M. (1975). *Fritz*. Saturday Review Press, E. P. Dutton & Co.
Shepherd, C., & Beail, N. (2017). A systematic review of the effectiveness of psychoanalysis, psychoanalytic and psychodynamic psychotherapy with adults with intellectual and developmental disabilities: progress and challenges. *Psychoanalytic Psychotherapy*, *31*(1), 94–117. https://doi.org/10.1080/02668734.2017.1286610
Sherman, R. (1999). Family therapy: The art of integration. In R. E. Watts (Ed.), *Intervention and strategies in counseling and psychotherapy* (pp. 101–134). Taylor and Francis.
Sherry, J. (2010). *Carl Gustav Jung: Avant-garde conservative*. Palgrave Macmillan.
Shoesmith, E., Charura, D., & Surr, C. (2021). Acceptability and feasibility study of a six-week person-centred, therapeutic visual art intervention for people with dementia. *Arts & Health*, *13*(3), 296–314. https://doi.org/10.1080/17533015.2020.1802607
Siegel, D. J. (2006). An interpersonal neurobiology approach to psychotherapy. *Psychiatric Annals*, *34*(6), 248–256.
Siegel, D. J. (2013). *Brainstorm: The power and purpose of the teenage brain*. Penguin.
Siegel, D. J. (2017). Interpersonal connection, compassion, and well-being: The science and art of healing relationship. In J. Loizzo, M. Neale, & E. J. Wolf (Eds.), *Advances in contemplative psychotherapy: Accelerating healing and transformation* (pp. 118–130). Routledge.
Siegel, D. J. (2021). *The healthy mind platter. Dr. Dan Siegel. https://drdansiegel.com/healthy-mind-platter/*
Sills, C., Lapworth, P., & Desmond, B. (2012). *An introduction to gestalt*. SAGE Publications.
Silverman, D. (2005) What works in psychotherapy and how do we know? What evidence-based practice has to offer. *Psychoanalytic Psychology*, *22*(2), 306–312. https://doi.org/10.1037/0736-9735.22.2.306
Simon, R. (2007, March/April) The top 10: The most influential therapists of the past quarter-century. *Psychotherapy Networker*. https://www.psychotherapynetworker.org/magazine/article/661/the-top-10
Singh, A. A., Appling, B., & Trepal, H. (2020). Using the multicultural and social justice counseling competencies to decolonize counseling practice: The important roles of theory, power, and action. *Journal of Counseling & Development*, *98*, 261–271. https://doi.org/10.1002/jcad.12321
Singh, A. A., & Moss, L. (2016). Using relational-cultural theory in LGBTQ counseling: Addressing heterosexism and enhancing relational competencies. *Journal of Counseling and Development*, *94*, 379–382. https://doi.org/10.1002/jcad.12095
Singh-Manoux, A., Kivimaki, M., Glymour, M., Elbaz, A., Berr, C., Ebmeier, K., Ferrie, J. E. & Dugravot, A. (2012). Timing of onset of cognitive decline: Results from Whitehall II prospective cohort study. *BMJ*, *344*(7840), D7622. https://doi.org/10.1136/bmj.d7622
Skinner, B. F. (1957). *Verbal behavior*. Appleton-Century-Crofts.
Skovlund, H. (2011). Overcoming problems of relativism in postmodern psychotherapy. *Journal of Contemporary Psychotherapy*, *41*, 187–198. https://doi.org/10.1007/s10879-010-9166-9
Smith, T. W. (1989). Assessment in rational–emotive therapy: Empirical access to the ABCD model. In M. E. Bernard & R. DiGiuseppe (Eds.), *Inside rational–emotive therapy: A critical appraisal of the theory and therapy of Albert Ellis* (pp. 135–152). Academic Press.
Smuts, J. C. (1926). *Holism and evolution*. Macmillan.
Snyder, K., Lambert, J., & Twohig, M. P. (2011). Defusion: A behavior-analytic strategy for addressing private events. *Behavior Analysis in Practice*, *4*(2), 4–13. https://doi.org/10.1007/bf03391779
Sokhadze, E. T. (2016). Lessons learned from Peniston's brainwave training protocol. In A. Martins-Mourao & C. Kerson (Eds.), *Alpha theta training in the 21st century: A handbook for clinicians and practitioners* (pp. 105–132). Foundation for Neurofeedback and Neuromodulation Research.
Sokhadze, E. M., Cannon, R. L., & Trudeau, D. L. (2008). EEG biofeedback as a treatment for substance use disorders: Review, rating of efficacy, and recommendations for further research. *Applied Psychophysiology and Biofeedback*, *33*, 1–28. https://doi.org/10.1007/s10484-007-9047-5
Sokhadze, E. M., Trudeau, D. L., & Cannon, R. L. (2014). Treating addiction disorders. In *Clinical Neurotherapy* (pp. 265–299). Elsevier. https://doi.org/10.1016/B978-0-12-396988-0.00011-8

Sorkhabi, N. & Mandara, J. (2013). Are the effects of Baumrind's parenting styles culturally specific or culturally equivalent? In R. E. Larzelere, A. S. Morris, & A. W. Harrist (Eds.), *Authoritative parenting: Synthesizing nurturance and discipline for optimal child development* (pp. 113–135). American Psychological Association.

Spaeth, D. (2019). Religious and spiritual diversity and humanistic psychology. In L. Hoffman, H. Cleare-Hoffman, N. Granger, & D. St. John (Eds.), *Humanistic approaches to multiculturalism and diversity* (pp. 203–214). Routledge.

Spencer, R., Jordan, J. V., & Sazama, J. (2004). Growth-promoting relationships between youth and adults: A focus group study. *Families in Society: The Journal of Contemporary Social Services, 85*, 354–362. https://doi.org/10.1177%2F104438940408500313

Sperry, L. (2018). Achieving evidence-based status for Adlerian therapy: Why it is needed and how to accomplish it. *The Journal of Individual Psychology*, *74*(3), 247–263. https://doi.org/10.1353/jip.2018.0017

Spiegel, R. (2004, June 3). *Cognitive behavior therapy's controversial founder. All Things Considered:* National Public Radio. https://www.npr.org/2004/06/03/1921765/cognitive-behavior-therapys-controversial-founder

Spinelli, E. (2015). *Practicing existential psychotherapy: The relational world* (2nd ed.). SAGE Publications.

Starr, A. (1973). Sociometry of the family. In H. H. Mosak (Ed.), *Alfred Adler: His influence on psychology today.* Noyes Press.

Steele, J. M. (2020). A CBT approach to internalized racism among African Americans. *International Journal for the Advancement of Counselling, 42*, 217–233. https://doi.org/10.1007/s10447-020-09402-0

Stein, H. T. (n.d.a). *Classical Adlerian quotes. Feeling of inferiority.* Alfred Adler Institute of Northwestern Washington. http://www.adlerian.us/qu-infer.htm

Stein, H. T. (n.d.b). *Classic Adlerian quotes: Religion*. Alfred Adler Institute of Northwestern Washington. http://www.adlerian.us/qu-relig2.htm

Stein, H. T. & Edwards, M. E. (2002). Adlerian psychotherapy. In Herson, M. & Sledge, M. H. (1st ed.), *Encyclopedia of Psychotherapy* (Vol. 1, pp. 23–31). Elsevier Science.

Stein, H. T. (2008). Adler's legacy: Past, present, and future. *Journal of Individual Psychology, 64*(1), 1–20.

Stein, H. T., & Edwards, M. E. (1998). Alfred Adler: Classical theory and practice. In P. Marcus & A. Rosenberg (Eds.), *Psychoanalytic versions of the human condition: Philosophies of life and their impact on practice* (pp. 64–93). New York University Press.

Stein, M. (1982). The aims and goals of Jungian analysis. In M. Stein (Ed.), *Jungian analysis* (pp. 27–46). Open Court.

Steinem, G. (1992). *Revolution from within: A book on self-esteem*. Little, Brown and Company.

Steinem, G. (1994). *Moving beyond words*. Simon and Schuster.

Steinem, G. (2008, January 8). Women are never front-runners. *The New York Times*. http://www.nytimes.com/2008/01/08/opinion/08steinem.html

Stepansky, P. E. (2009). *Psychoanalysis at the margins*. Other Press.

Stephen, S., Elliott, R., & Macleod, R. (2011). Person-centred therapy with a client experiencing social anxiety difficulties: A hermeneutic single case efficacy design. *Counselling and Psychotherapy Research*, *11*(1), 55–66. https://doi.org/10.1080/14733145.2011.546203

Stephenson, L., & Hale, B. (2020). An exploration into effectiveness of existential–phenomenological therapy as a U.K. NHS psychological treatment intervention. *Journal of Humanistic Psychology, 60*(3), 436–452. https://doi.org/10.1177/0022167817719178

Stere, L. K. (1985). Feminist assertiveness training: Self-esteem groups as skill training for women. In L.B. Rosewater & L.E.A. Walker (Eds.), *Handbook of feminist therapy: Women's issues in psychotherapy* (pp. 51–61). Springer.

Stewart, C., G. White, R., Ebert, B., Mays, I., Nardozzi, J., & Bockarie, H. (2016). A preliminary evaluation of acceptance and commitment therapy (ACT) training in Sierra Leone. *Journal of Contextual Behavioral Science, 5*(1), 16–22. https://doi.org/10.1016/j.jcbs.2016.01.001

Stewart, I., Barnes-Holmes, D., Hayes, S. C., & Lipkens, R. (2001). Relations among relations: Analogies, metaphors, and stories. In S. C. Hayes, D. Barnes-Holmes, & B. Roche (Eds.), *Relational frame theory: A post-Skinnerian account of human language and cognition* (pp. 73–86). Springer.

Stojek, M. M., McSweeney, L. B., & Rauch, S. (2018). Neuroscience informed prolonged exposure practice: Increasing efficiency and efficacy through mechanisms. *Frontiers in Behavioral Neuroscience, 12*, 281. https://doi.org/10.3389/fnbeh.2018.00281

Storlie, C. A., Albritton, K., & Cureton, J. L. (2017). Familial and social influences in career exploration for female youth of color: A study of relational cultural theory. *The Family Journal, 25*, 351–358. https://doi.org/10.1177.1066480717732142

Storr, A. (1973). *C. G. Jung*. The Viking Press.

Streeck-Fischer, A., Logé, C., & Salzer, S. (2020). The psychoanalytic–interactional method (PiM) for adolescents with borderline personality disorder. *Adolescent Psychiatry, 10*(3), 172–181. https://doi.org/10.2174/2210676610666200327164953

Street, R. F. (1931). *A Gestalt completion test: A study of a cross-section of intellect*. Columbia University Press.

Stripling, T. (2021). Gestalt interventions benefiting children and adolescents: A literature review. *Gestalt Review, 25*(2), 197–220. https://doi.org/10.5325/gestaltreview.25.2.0197

Strong, T., & Busch, R. (2013). DSM-5 and evidence-based family therapy. *Australian & New Zealand Journal of Family Therapy, 34*(2), 90–103. https://doi/org/10.1002/anzf.1009

Sturm, D. C. (2015). Relational–cultural theory. In E. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 2, pp. 648–640). SAGE Publications.

Substance Abuse and Mental Health Service Administration. (n.d.). *Evidence-based practices resource center*. https://www.samhsa.gov/resource-search/ebp
Substance Abuse and Mental Health Services Administration. (2015). *Racial/ethnic differences in mental health service use among adults*. https://www.samhsa.gov/data/report/racialethnic-differences-mental-health-service-use-among-adults
Sue, D. W. (1978). Eliminating cultural oppression in counseling: Toward a general theory. *Journal of Counseling Psychology, 25*(5), 419–428.
Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice* (8th ed.). Wiley.
Sue, S., & Zane, N. (2009). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *Asian American Journal of Psychology, S*(1), 3–14. https://psycnet.apa.org/doi/10.1037/1948-1985.S.1.3
Suitt, K. G., Franklin, C., & Kim, J. (2016). Solution-focused brief therapy with Latinos: A systematic review. *Journal of Ethnic & Cultural Diversity in Social Work, 35*(1), 50–67. https://doi.org/10.1080/15313204.2015.1131651
Suldo, S. M. & Huebner, E. S. (2004). The role of life satisfaction in the relationship between authoritative parenting dimensions and adolescent problem behavior. In A. Dannerbeck, F. Casas, M. Sadurni, & G. Coenders (Eds.), *Quality-of-life research on children and adolescents* (pp. 165–195). Kluwer Academic Publishers.
Sullivan, M. B., Erb, M., Schmalzl, L., Moonaz, S., Noggle Taylor, J., & Porges, S. W. (2018). Yoga therapy and polyvagal theory: The convergence of traditional wisdom and contemporary neuroscience for self-regulation and resilience. *Frontiers in Human Neuroscience, 12*, 67. https://doi.org/10.3389/fnhum.2018.00067
Sun, S., Hoyt, W. T., Brockberg, D., Lam, J., & Tiwari, D. (2016). Acculturation and enculturation as predictors of psychological help-seeking attitudes (HSAs) among racial and ethnic minorities: A meta-analytic investigation. *Journal of Counseling Psychology, 63*(6), 617–632. https://doi.org/10.1037/cou0000172
Supeni, I., & Jusoh, A. J. (2021). Choice theory and reality therapy to prevent sexual misconduct among youth: A current review of literature. *International Journal of Education, Information Technology, and Others*, *4*(3), 428–436.
Surrey, J. L. (1997). What do you mean by mutuality in therapy? In Jordan, J. V. (Ed.), *Women's growth in diversity: More writings from The Stone Center* (pp. 311–330). Guilford Press.
Swales, M. A., & Heard, H. L. (2017). *Dialectical behavior therapy* (2nd ed.). Routledge.
Swan, A. M., & Ceballos, P. (2020). Person-centered conceptualization of multiculturalism and social justice in counseling. *Person-Centered & Experiential Psychotherapies*, *19*(2), 154–167. https://doi.org/10.1080/14779757.2020.1717981
Sweeney, T. (2019). *Adlerian counseling: A practitioner's approach* (6th ed.). Routledge.
Szasz, T. (1961). *The myth of mental illness*. Paul B. Hoeber, Inc.
Taghiyar, Z., & Pahlavanzade, F. (2019). The effectiveness of narrative therapy on marital commitment and Sexual satisfaction. *Knowledge & Research in Applied Psychology*, *20*(2), 110–120.
Tantillo, M., & Sanftner, J. (2003). The relationship between perceived mutuality and bulimic symptoms, depression, and therapeutic change in group. *Eating Behaviors, 3*, 349–364. https://doi.org/10.1016/S1471-0153(02)00077-6
Tantillo, M., & Sanftner, J. (2010). Measuring perceived mutuality in women with eating disorders: The development of the Connection-Disconnection Scale. *Journal of Nursing Measurement*, 18, 100–119. https://doi.org/10.1891/1061-3749.18.2.100
Tardif, C. L., Gauthier, C. J., Steele, C. J., Bazin, P.-L., Schäfer, A., Schaefer, A., Tuner, R., & Villringer, A. (2016). Advanced MRI techniques to improve our understanding of experience-induced neuroplasticity. *NeuroImage*, *131*, 55–72. https://doi.org/10.1016/j.neuroimage.2015.08.047
Tart, C. T. (1969). *Altered states of consciousness: A book of readings*. Wiley.
Tartakovsky, M. (2019, Nov. 10). *The surprising history of the lobotomy*. https://psychcentral.com/blog/the-surprising-history-of-the-lobotomy/
TEDx Talks. (2016, January 23). *Psychological flexibility: How love turns pain into purpose* [Video]. YouTube. https://youtu.be/o79_gmO5ppg
ten Have, M., Verheul, R., Kaasenbrood, A., van Dorsselaer, S., Tuithof, M., Kleinjan, M., & de Graaf, R. (2016). Prevalence rates of borderline personality disorder symptoms: A study based on the Netherlands Mental Health Survey Incidence Study. *BMC Psychiatry, 16*, 1–10. https://doi.org/10.1186/s12888-016-0939-x
Teusch, R. (2021). A people's history of psychoanalysis: From Freud to liberation psychology by Daniel Jose Gaztambide [Review]. *American Imago, 73*, 539–553. https://doi.org/10.1353/aim.2021.0019
Thabrew, H., Ruppeldt, P., & Sollers, J. J. (2018). Systematic review of biofeedback interventions for addressing anxiety and depression in children and adolescents with long-term physical conditions. *Applied Psychophysiology and Biofeedback*, *43*(3), 179–192. https://doi.org/10.1007/s10484-018-9399-z
The Guardian. (2008, June 17). *Michael White: Innovative Australian psychotherapist who developed narrative therapy in the 1980s*. https://www.theguardian.com/world/2008/jun/17/australia
The Taos Institute. (2022). David Epston. https://www.taosinstitute.net/about-us/people/honorary-associates/david-epston
Thibault, R. T., Lifshitz, M., Birbaumer, N., & Raz, A. (2015). Neurofeedback, self-regulation, and brain imaging: Clinical Science and fad in the service of mental disorders. *Psychotherapy and Psychosomatics*, *84*, 193–207. https://doi:10.1159/000371714
Thomas, F. N., & Nelson, T. S. (2007). Assumptions and practices within the solution-focused brief therapy tradition. In T. S. Nelson & F. N. Thomas (Eds.), *Handbook of solution-focused brief therapy: Clinical applications* (pp. 3–24). Haworth Press.
Toporek, R. L., & Daniels, J. A. (2018). *ACA advocacy competencies*. American Counseling Association. https://www.counseling.org/docs/default-source/competencies/aca-advocacy-competencies-updated-may-2020.pdf?sfvrsn=f410212c_4
Törneke, N. (2010). *Learning RFT: An introduction to relational frame theory and its clinical application*. Context Press.

Törneke, N., Luciano, C., & Salas, S. V. (2008). Rule-governed behavior and psychological problems. *International Journal of Psychology and Psychological Therapy, 8*(2), 141–156.
Tower, P. (2011). CBT theory. In W. Dryden & R. Branch (Eds.), *The CBT handbook* (pp. 25–44). SAGE Publications.
Travis, S. P. (2021). A delphi study: How, can, and should individual psychology demonstrate efficacy and effectiveness given evidence-based practice evaluation standards? *The Journal of Individual Psychology*, *77*(1), 4–23. https://doi.org/10.1353/jip.2021.0001
Trepal, H. (2010). Exploring self-injury through a relational-cultural lens. *Journal of Counseling & Development*, *88*, 494–499. https://doi.org/10.1002/j.1556-6678.2010.tb00051.x
Trepper, T. S. Dolan, Y., McCollum, E. E., Nelson, T. (2006). Steve de Shazer and the future of solution-focused therapy. *Journal of Marital and Family Therapy, 32*(2), 133–139.
Trepper, T. S., McCollum, E. E., De Jong, P., Korman, H., Gingerich, W., & Franklin, C. (2014). Solution-focused therapy treatment manual for working with individuals. In J. S. Kim (Ed.), *Solution-focused brief therapy: A multicultural approach* (pp. 14–31). SAGE Publications.
Trowell, J., & Tsiantis, J. (Eds.). (2018). *Assessing change in psychoanalytic psychotherapy of children and adolescents: Today's challenge*. Routledge.
Truax, C. B., & Mitchell, K. M. (1961). Research on certain therapist interpersonal skills in relation to process and outcome. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (3rd ed.). Wiley.
Tschuschke, V., Crameri, A., Koemeda, M., Berglar, J., Muth, K., Staczan, P., von Wyl, A., Schulthess, P., & Koemeda-Lutz, M. (2015). The role of therapists' treatment adherence, professional experience, therapeutic alliance, and clients' severity of psychological problems: Prediction of treatment outcome in eight different psychotherapy approaches. Preliminary results of a naturalistic study. *Psychotherapy Research*, *25*, 420–434. https://doi.org/10.1080/10503307.2014.896055
Tschuschke, V., Crameri, A., Koemeda, M., Schulthess, P., von Wyl, A., & Weber, R. (2010). Fundamental reflections on psychotherapy research and initial results of the naturalistic psychotherapy study on outpatient treatment in Switzerland (PAP-S). *International Journal for Psychotherapy*, *14*, 247–256.
Tucker, C. T. (2015). Relational–cultural theory. In E. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 2, pp. 887–890). SAGE Publications.
Tummala-Narra, P. (2009). The relevance of a psychoanalytic perspective in exploring religious and spiritual identity in psychotherapy. *Psychoanalytic Psychology, 26,* 81–95. https://doi.org/10.1037/a0014673
Tummala-Narra, P. (2013). Psychoanalytic applications in a diverse society. *Psychoanalytic Psychology, 30*(3), 471–487. https://doi.org/10.1037/a0031375
Tummala-Narra, P. (2015). Cultural competence as a core emphasis of psychoanalytic psychotherapy. *Psychoanalytic Psychology, 32*(2), 275–292. https://doi.org/10.1037/a0034041
Turner, D., Gaag, M., Karyotaki, E., & Cuijpers, P. (2014). Psychological interventions for psychosis: A meta-analysis of comparative outcome studies. *American Journal of Psychiatry, 171*(5), 523–538. https://doi.org/10.1176/appi.ajp.2013.13081159
Twohig, M. P., Hayes, S. C., Plumb, J. C., Pruitt, L. D., Collins, A. B., Hazlett-Stevens, H., & Woidneck, M. R. (2010). A randomized clinical trial of acceptance and commitment therapy versus progressive relaxation training for obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology, 78*(5), 705–716. https://psycnet.apa.org/doi/10.1037/a0020508
Twohig, M. P., & Levin, M. E. (2017). Acceptance and commitment therapy as a treatment for anxiety and depression: A review. *Psychiatric Clinics of North America*, *40*(4), 751–770. https://doi.org/10.1016/j.psc.2017.08.009
Urofsky, R., Engels, D., & Engebretson, K. (2008). Kitchener's principle ethics: Implications for counseling practice and research. *Counseling and Values*, *53*(1), 67–78. https://doi.org/10.1002/j.2161-007X.2009.tb00114.x
Ursano, R. J., Sonnenberg, S. M., & Lazar, S. G. (2004). *Concise guide to psychodynamic psychotherapy: Principles and techniques of brief, intermittent, and long-term psychodynamic psychotherapy* (3rd ed.). American Psychiatric Publishing.
U.S. National Library of Medicine. (2015). *Dr. Jean Baker Miller.* https://cfmedicine.nlm.nih.gov/physicians/biography_225.html
Valdez, L. A., Flores, M., Ruiz, J., Oren, E., Carvajal, S., & Garcia, D. O. (2018). Gender and cultural adaptations for diversity: A systematic review of alcohol and substance abuse interventions for Latino males. *Substance Use & Misuse*, *53*(10), 1608–1623. https://doi.org/10.1080/10826084.2017.1417999
Vallejos, L., & Johnson, Z. (2019). Multicultural competencies in humanistic psychology. In L. Hoffman, H. Cleare-Hoffman, N. Granger, & D. St. John (Eds.), *Humanistic approaches to multiculturalism and diversity* (pp. 63–75). Routledge.
van Deurzen, E. (2012). *Existential counseling and psychotherapy in practice* (3rd ed.). SAGE Publications.
van Deurzen & Adams, M. (2016). *Skills in existential counseling and psychotherapy* (2nd ed.). SAGE Publications.
van Deurzen, E., & Kenward, R. (2005). *Dictionary of existential psychotherapy and counseling.* SAGE Publications.
Van Dijk, S. (2012). *DBT made simple: A step-by-step guide to dialectical behavior therapy.* New Harbinger.
Van Doren, J., Arns, M., Heinrich, H., Vollebregt, M. A., Strehl, U., & K. Loo, S. (2018). Sustained effects of neurofeedback in ADHD: A systematic review and meta-analysis. *European Child & Adolescent Psychiatry*, (0123456789), 1–13. https://doi.org/10.1007/s00787-018-1121-4
Van Nuys, D (Host). (2007). *William Glasser and Carleen Glasser on happier marriages [Audio podcast].* CenterSite, LLC. https://podcasts.apple.com/au/podcast/william-and-carlene-glasser-on-happier-marriages/id218827921?i=1000024285182
Vazquez, L. A. (2014). Integration of multicultural and psychoanalytic concepts: A review of three case examples with women of color. *Psychoanalytic Psychology, 31*(3), 435–448. https://doi.org/10.1037/a0036341

Velasquez, M. (2017). *Philosophy: A text with readings*. Cengage Learning.
Viktor Frankl Institute. (n.d.a). *About Viktor Frankl*. https://www.viktorfranklinstitute. org/about-viktor-frankl/
Viktor Frankl Institute. (n.d.b). *The Institute*. https://www.univie.ac.at/logotherapy/institute_agendaE.html
Visser, C. F. (2013). The origin of the solution-focused approach. *International Journal of Solution-Focused Practices*, *1*, 10–17. https://doi.org/10.14335/ijsfp.v1i1.10
Vos, J. (2018). *Meaning in life: An evidence-based handbook for practitioners*. Palgrave McMillan.
Vos, J. (2019). A review of research on existential-phenomenological therapies. In E. van Deurzan, E. Craig, A. Längle, K. J. Schneider, D. Tantam, & S. du Plock (Eds.), *The Wiley world handbook of existential therapy* (pp. 592–614). Wiley.
Vos, J., Craig, M., & Cooper, M. (2015). Existential therapies: A meta-analysis of their effects on psychological outcomes. *Journal of Consulting & Clinical Psychology, 83*(1), 115–128. https://doi.org/10.1037/a0037167.
Vromans, L. P., & Schweitzer, R. B. (2011). Narrative therapy for adults with major depressive disorders: Improved symptoms and interpersonal outcomes. *Psychotherapy Research, 21*(1), 4–15. https://doi.org/10.1080/10503301003591792
Wagner, H. H. & Hill, N. R. (2015). Becoming counselors through growth and learning: The entry transition process. *Counselor Education & Supervision*, *54*, 189–202. https://doi.org/10.1002/ceas.12013
Walsh, R. A., & McElwain, B. (2002). Existential psychotherapies. In D. J. Cain (Ed.)., *Humanistic psychotherapies: Handbook of research and practice* (pp. 253–278). American Psychological Association.
Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Erlbaum.
Wampold, B. E. (2010). The research evidence for common factors models: A historically situated perspective. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change* (2nd ed., pp. 49–82). American Psychological Association.
Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*, 270–277. https://doi.org/10.1002/wps.20238
Wampold, B. E. (2019). *The basics of psychotherapy: An introduction to theory and practice* (2nd ed.). American Psychological Association.
Wampold, B. E., & Budge, S. L. (2012). The relationship—and its relationship to the common and specific factors in psychotherapy. *The Counseling Psychologist, 40*, 601–623.
Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). Routledge.
Wang, D. C., & Tan, S. (2016). Dialectical behavioral therapy (DBT): Empirical evidence and clinical applications from a Christian perspective. *Journal of Psychology and Christianity, 35*, 68–76.
Warren, J. M. (2010). The impact of rational emotive behavior therapy on teacher efficacy and student achievement. *Journal of School Counseling, 8*(11) (EJ885064). *ERIC. https://eric.ed.gov/?id=EJ885064*
Warren, J. M., & Dowden, A. R. (2012). Elementary school teachers' beliefs and emotions: Implications for school counselors and counselor educators. *Journal of School Counseling, 10*(19). http://www.jsc.montant/edu/articles/v10n19.pdf
Warren, J. M., & Robinson, G. (2015). Addressing barriers to effective RTI through school counselor consultation: A social justice approach. *Electronic Journal for Inclusive Education*, 3(4), article 3.
Watkins, C. E., & Guarnaccia, C. A. (1999). The scientific study of Adlerian theory. In R. E. Watts (Ed.), *Intervention and strategies in counseling and psychotherapy* (pp. 207–230). Taylor and Francis.
Watson, J. C. (2016). The role of empathy in psychotherapy: Theory, research, and practice. In D. J. Cain, K. Keenan, & S. Rubin (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 115–145). American Psychological Association. https://doi.org/10.1037/14775-005
Watt, D. F., & Pankseep, J. (Eds.). (2016). *Psychology and neurobiology of empathy*. Nova Science Publishers, Inc. http://www.novapublishers.com/
Watts, R. E. (2000). Biblically based Christian spiritual and Adlerian psychotherapy. *Journal of Individual Psychology, 56*(3), 316–328.
Watts, R. E. (2007). Counseling conservative Christian couples: A spiritually sensitive perspective. In O. J. Morgan (Ed.), *Counseling & spirituality: Views from the profession*. Lahaska/Houghton Mifflin.
Watts, R. E. (2013, April 1). Reflecting "as if." *Counseling Today*. https://ct.counseling.org/2013/04/reflecting-as-if/
Watts, R. E. (2015a). Adler, Alfred. In E. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 24–26). SAGE Publications.
Watts, R. E. (2015b, April 1). *Reflecting 'as if.' Counseling Today*. http://ct.counseling.org/2013/04/reflecting-as-if/
Watts, R. E., & Holden, J. M. (1994). Why continue to use "fictional finalism?" *Individual Psychology, 50*, 161–163.
Watts, R. E., & Shulman, B. H. (2003). Integrating Adlerian and constructive therapies: An Adlerian perspective. In R. E. Watts (Ed.), *Adlerian, cognitive, and constructivist therapies: An integrative dialogue* (pp. 9–37). Spring Publishing.
Weber, M., Davis, K., & McPhie, L. (2006). Narrative therapy, eating disorders, and groups: Enhancing outcomes in rural NSW. *Australian Social Work, 59*(4), 391–405. https://psycnet.apa.org/doi/10.1080/03124070600985970
Weinberg, D. (2008). The philosophical foundations of constructionist research. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of constructionist research* (pp. 13–40). Guilford Press.
Weinberg, D. (2008). The philosophical foundations of constructionist research. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of constructionist research* (pp. 13–40). Guilford Press.
Weiss, L. (1985). Getting to "no" and beyond. In L.B. Rosewater, & L.E.A. Walker (Eds.), *Handbook of Feminist Therapy: Women's Issues in Psychotherapy* (pp. 62–70). Springer.

Weishaar, M. E. (1993). *Aaron T. Beck*. SAGE Publications.
Weishaar, M. E. (2015). Aaron T. Beck. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 85–90). SAGE Publications.
Weissman, J., Pratt, L. A., Miller, E. A., & Parker, J. D. (2015). *Serious psychological distress among adults: United States, 2009–2013*. https://www.researchgate.net/profile/Judith_Weissman/publication/278410177_Serious_psychological_distress_among_adults_United_States_20092013._NCHS_data_brief_no_203._Hyattsville_MD_National_Center_for_Health_Statistics._2015/links/5580757308aed40dd8cd2748.pdf
Wellesley Centers for Women. (2016). *Profile of Judith V. Jordan*. www.wcwonline.org/Active-Researchers/Judith-v-jordan-phd
Weltmer, A. A. (1900). *Suggestion simplified*. American School of Magnetic Healing.
Wenzel, A., Dobson, K. S. & Hays, P. A. (2016). *Cognitive-behavioral therapy techniques and strategies*. American Psychological Association.
Westen, D. (1998). The scientific legacy of Sigmund Freud: Toward a psychodynamically informed psychological science. *Psychological Bulletin, 124*(3), 333–371. https://psycnet.apa.org/doi/10.1037/0033-2909.124.3.333
Wheeler, J. (2006). Riding the underground railroad: Insoo Kim Berg talks about the origins and future of the solution focused approach. *Solution News*, *2*(3), 3–6. http://solutions-centre.org/pdf/SolutionNews-2-3.pdf
White, C. (2009, October). Where did it all begin? Reflecting on the collaborative work of Michael White and David Epston. *Context*. https://dulwichcentre.com.au/where-did-it-all-begin-cheryl-white.pdf
White, C. (2011). Epilogue: Continuing the conversations. In M. White, *Narrative practice: Continuing the conversations* (pp. 157–179). W.W. Norton & Company.
White, M. (1991). Deconstruction and therapy. *Dulwich Centre Newsletter*, *3*, 21–40. Dulwich Centre Publications.
White, M. (1993). *Narrative therapy using a reflective team* [Video]. American Counseling Association.
White, M. (1995). *Re-authoring lives: Interviews and essays*. Dulwich Centre Publications.
White, M. (2000). *Reflections on narrative practice: Essays and interviews*. Dulwich Centre Publications.
White, M. (2002). Addressing personal failure. *International Journal of Narrative Therapy and Community Work*, *3*, 33–76.
White, M. (2007) *Maps of narrative practice*. W. W. Norton & Company.
White, M. (2011). *Narrative practice: Continuing the conversations*. W. W. Norton & Company.
White, M. (2012). Scaffolding a therapeutic conversation. In T. Malinen, S. J. Cooper, & F. N. Thomas (Eds.) *Masters of narrative and collaborative therapies* (pp. 121–170). Routledge.
White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. W. W. Norton & Company.
White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. W. W. Norton & Company.
White, M., Epston, D., & Andrews, J. (1994). *The best of friends: A live interview with Michael White* [Video]. Master's Works Video Productions.
Wick, D. T., Wick, J. K., & Peterson, N. (1997). Improving self-esteem with Adlerian adventure therapy. *Professional School Counseling, 1*(1), 53-56.
Wiker, B. (2013, February 25). *Benedict vs. the dictatorship of relativism*. *National Catholic Register*. http://www.ncregister.com/blog/benjamin-wiker/benedict-vs.-the-dictatorship-of-relativism
Wikimedia. (2012). *An experimental subject is partaking in an EEG experiment*. https://commons.wikimedia.org/w/index.php?title=Special:Search&limit=100&offset=0&profile=default&search=eeg&advancedSearch-current={}&ns0=1&ns6=1&ns12=1&ns14=1&ns100=1&ns106=1#/media/File:EEG.png
Wiles, N. J., Thomas, L., Turner, N., Garfield, K., Kounali, D., Campbell, J., Kessler, D., Kuyken, W., Lewis, G., Morrison, J., Williams, C., Peters, T. J., & Hollinghurst, S. (2016). Long-term effectiveness and cost-effectiveness of cognitive behavioural therapy as an adjunct to pharmacotherapy for treatment-resistant depression in primary care: Follow-up of the CoBalT randomised controlled trial. *The Lancet Psychiatry*, *3*(2), 137–144.
Wilkinson, B. D. (2018). The limits of neuroscience in counseling: A humanistic perspective and proposed model. *Journal of Humanistic Counseling*, *57*, 70–78. https://doi.org/10.1002/johc.12067
Wilkinson, T., Smith, D., & Wimberly, R. (2019). Trends in ethical complaints leading to professional counseling licensing boards disciplinary actions. *Journal of Counseling & Development*, *97*(1), 98–104. https://doi.org/10.1002/jcad.12239
William Glasser Institute. (n.d.a). *Reality therapy*. http://wglasser.com/our-approach/reality-therapy/
William Glasser Institute. (n.d.b). *Dr. William Glasser*. http://wglasser.com/about-us/biography/
William Glasser Institute. (n.d.c). *Quickstart guide to choice theory: Ten axioms of choice theory*. https://wglasser.com/quickstart-guide-to-choice-theory/#axioms
William Glasser International. (n.d.a). *Home*. https://www.wglasserinternational.org/
William Glasser International. (n.d.b). *CTRTC evidence based*. http://www.wglasserinternational.org/research/evid-based/
Williams, J. M., McMahon, H. G., & Goodman, R. D. (2015). Eco-webbing: A teaching strategy to fa(cilitate critical consciousness and agency. *Counselor Education and Supervision*, *54*, 82–97. https://doi.org/10.1002/ceas.12006
Wilson, C. J., & Cottone, R. R. (2013). Using cognitive behavior therapy in clinical work with African American children and adolescents: A review of the literature. *Journal of Multicultural Counseling and Development*, *41*(3), 130–143. https://doi.org/10.1002/j.2161-1912.2013.00032.x
Wilson, P. M., & Appel, S. W. (2013). Existential counselling and psychotherapy with Māori clients. *Asia Pacific Journal of Counselling and Psychotherapy*, *4*, 137–146. https://doi.org/10.1080/21507686.2013.822400
Winburn, A., Perepiczka, M., Frankum, J., & Neal, S. (2020). Play therapists' empathy levels as a predictor of self-perceived advocacy competency. *International Journal of Play Therapy*, *29*(3), 144–154. https://doi.org/10.1037/pla0000119

Wingard, B. & Lester, J. (2001). *Telling our stories in ways that make us stronger.* Dulwich Centre Publications.
Winslade, J. M. (2005). Utilising discursive position in counselling. *British Journal of Guidance & Counselling, 33*(3), 351–364. https://doi.org/10.1080/03069880500179541
Winslade, J., & Geroski, A. (2008). A social constructionist view of development. In K. Kraus (Ed.), *Lenses: Applying lifespan development theories in counseling* (pp. 88–113). Lahaska Press.
Winter, D. A. (2007). Constructivist and humanistic therapies. In E. Freeman & M. Power (Eds.), *Handbook of evidence-based psychotherapies: A guide of research and practice* (pp. 123–140). Wiley.
Wittgenstein, L. (1963). *Philosophical investigations* (G. E. M. Anxcombe, Trans.). Macmillan.
Woidneck, M. R., Pratt, K. M., Gundy, J. M., Nelson, C. R., & Twohig, M. P. (2012). Exploring cultural competence in acceptance and commitment therapy outcomes. *Professional Psychology: Research and Practice, 43*, 227–233. https://doi.org/10.1037/a0026235
Wolfert, R. (2015). The spiritual dimensions of gestalt therapy. In B. J. Mistler & P. Brownell (Eds.), *Global perspectives on research, theory, and practice: A decade of gestalt!* (pp. 197–202). Cambridge Scholars Publishing.
Wolfgang, C. H. (2009). *Solving discipline and classroom management problems: Methods and models for today's teachers* (7th ed.). Wiley.
Woll, C. F. J., & Schönbrodt, F. D. (2019). A series of meta-analytic tests of the efficacy of long-term psychoanalytic psychotherapy. *European Psychologist, 25*, 51–72. https://doi.org/10.1027/1016-9040/a000385
Wollants, G. (2012). *Gestalt therapy: Therapy of the situation*. SAGE Publications.
Wong, Y. J. (2015). The psychology of encouragement: Theory, research, and applications. *The Counseling Psychologist, 43*(2), 178–216. https://doi.org/10.1177/0011000014545091
Wong, Y. J. (2015). The psychology of encouragement: *Theory, Research, and Applications, 32*, 178–176. https://doi.org/10.1177/0011000014545091
Wood, C. (2015). Synchronicity. In M. Cardin (Ed.). *Ghosts, spirits, and psychics: The paranormal from alchemy to Zombies* (pp. 320–323). ABC-CLIO.
Woods, D. W., Wetterneck, C. T., & Flessner, C. A. (2006). A controlled evaluation of acceptance and commitment therapy plus habit reversal for trichotillomania. *Behaviour Research and Therapy, 44*(5), 639–656. https://doi.org/10.1016/j.brat.2005.05.006
Woon, F. L., & Hedges, D. W. (2008). Hippocampal and amygdala volumes in children and adults with childhood maltreatment-related posttraumatic stress disorder: A meta-analysis. *Hippocampus, 18*, 729–736. https://doi.org/10.1002/hipo.20437
World Health Organization. (2022). *World Bank and Who: Half the world lacks access to essential health services, 100 million still pushed into extreme poverty because of health expenses.* https://www.who.int/news/item/13-12-2017-world-bank-and-who-half-the-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses
Wright, J. (2008). *Transcript of Jeremiah Wright's April 26th, 2008 speech to NAACP.* CNN. http://edition.cnn.com/2008/POLITICS/04/28/wright.transcript/index.html
Wubbolding, R. (2000). *Reality therapy for the 21st century*. Brunner-Routledge.
Wubbolding, R. (2012). *Reality therapy: Theories of psychotherapy series*. American Psychological Association.
Wubbolding, R. (2015a). William Glasser. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 1, pp. 462–464). SAGE Publications.
Wubbolding, R. (2015b). Reality therapy. In E. S. Neukrug (Ed.), *The SAGE encyclopedia of theory in counseling and psychotherapy* (Vol. 2, pp. 856–857). SAGE Publications.
Wubbolding, R. (2015c). The voice of William Glasser: Accessing the continuing evolution of reality therapy. *Journal of Mental Health Counseling, 37*(3), 189–205. https://doi.org/10.17744/mehc.37.3.01https://doi.org/10.17744/mhc/3/3/01
Wubbolding, R. (2017). *Reality therapy and self-evaluation, the key to client change*. American Counseling Association.
Wubbolding, R. (2019a). *A choice theory psychology guide to depression: Lift your mood.* Robert Wubbolding.
Wubbolding, R. (2019b). The relationship between professional diversity/multicultural guidelines and choice theory/reality therapy. *International Journal of Choice Theory and Reality Therapy, 38*(2), 36–42.
Wubbolding, R. (2020). *Cycle of counseling, therapy, coaching, managing, supervising, and parenting* (21st Rev. ed.) [Chart]. Center for Reality Therapy.
Wubbolding, R., & Brickell, J. (2015). *Counselling with reality therapy* (2nd ed.). Speechmark Publishing.
Wubbolding, R., & Wubbolding, S. (2013). *Counseling profession loses a friend and a legend of counseling.* American Counseling Association. https://www.counseling.org/news/updates/news-detail/2013/08/28/counseling-profession-loses-a-friend-and-a-legend-of-counseling
Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive behavior therapy for schizophrenia: Effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin, 34*(3), 523–537. https://doi.org/10.1093/schbul/sbm114
Xi, C., Zhu, Y., Niu, C., Zhu, C., Lee, T. M. C., Tian, Y., & Wang, K. (2011). Contributions of subregions of the prefrontal cortex to the theory of mind and decision making. *Behavioural Brain Research, 22*, 587–593. https://doi.org/10.1016/j.bbr.2010.09.031
Yalom, I. D. (1980). *Existential psychotherapy.* Basic Books.
Yonteff, G. M. (1976). Theory of Gestalt therapy. In C. Hatcher & P. Himelstein (Eds.), *The handbook of Gestalt therapy* (pp. 213–221). Jason Aronson.

Young, K. D., Zotev, V., Phillips, R., Misaki, M., Yuan, H., Drevets, W. C., & Bodurka, J. (2014). Real-time fMRI neurofeedback training of amygdala activity in patients with major depressive disorder. *PLoS ONE*, *9*(2), 1–13. https://doi.org/10.1371/journal.pone.0088785

Zalaquett, C. P., & Ivey, A. E. (2014). Neuroscience and psychology: Central issues for social justice leaders. In H. Friedman & C. Johnson (Eds.), *The Praeger handbook of social justice and psychology* (Vol. II, pp 173–192). Praeger.

Zalaquett, C. P., & Ivey, A. E. (2018). The role of neuroscience in advancing social justice counseling. In C. Lee (Ed.), *Counseling for social justice* (3rd ed., pp. 191–204). American Counseling Association.

Zalaquett, C., P., Ivey, A. E., & Ivey, M. B. (2018). *Essential theories of counseling and psychotherapy: Everyday practice in our diverse world*. Cognella Academic Publishing.

Zalaquett, C. P., & Wubbolding, R. R. (2016). An interview with Robert E. Wubbolding. *International Journal of Choice Theory & Reality Therapy*, *35*(2), 36–44.

Zandberg, L., Kaczkurkin, A. N., McLean, C. P., Rescorla, L., Yadin, E., & Foa, E. B. (2016). Treatment of adolescent PTSD: The impact of prolonged exposure versus client-centered therapy on co-occurring emotional and behavioral problems. *Journal of Traumatic Stress*, *29*(6), 507–514. https://doi.org/10.1002/jts.22138

Zettle, R. D. (2011). The evolution of a contextual approach to therapy: From comprehensive distancing to ACT. *International Journal of Behavioral Consultation and Therapy*, *7*(1), 76–82. http//dx.doi.org/10.1037/h0100929

Zielona-Jenek, O., Sakson-Obada, O., Czapcznska, A. (2019). Restoring the body: changes in body self in the course of a focusing and arts-based therapy program for female interpersonal trauma survivors. *Current Issues in Personality Psychology*, *7*(4), 324–340. https://doi.org/10.5114/CIPP.2019.92958

Zuroff, D. C., Shahar, G., Blatt, S. J., Kelly, A. C., & Leybman, M. J. (2016). Predictors and moderators of between-therapists and within-therapist differences in depressed outpatients' experiences of the Rogerian conditions. *Journal of Counseling Psychology*, *63*(2), 162–172. https://doi.org/10.1037/cou0000139

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